CAP- 3D COMMUNITY CARE & SUPPORT MODEL

For MSM & TG

Guidance for case management in the provision of care and support and preventive medicine for men who have sex with men and transgender in Community Based Organizations

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CONTENT:

FOREWORD

The CAP-3D Community Care and Support Model For Men Who Have Sex with Men(MSM) and Transgender People(TG) Manual was developed by drawing from the collective experiences of various community based organizations(CBOs) providing care and support to MSM and TG people living with HIV (PHIV). Their practical experience in the field is presented in the manual, complemented by health care knowledge from textbooks, journals, and national guidelines. This manual has been developed with the purpose of providing preventative medicine and case management guidance relating to the provision of care and support for MSM and TG, specifically tailored to be useful to the community based organizations serving these populations. The authors have structured the guidelines so that they parallel the treatment cascade. The manual initially addresses the prevention of new HIV infections and, after a positive diagnosis, helping PHIV to receive appropriate care and support, including CD4 testing and anti-retroviral treatment. A comprehensive care and support service delivery plan is essential for the retention of PHIV in the services to ensure that they receive continuous treatment.

The information in this manual is informed by the experiences of The POZ Home Center Foundation, CAREMAT, Service Workers in Group Foundation, The HIV Foundation Thailand, SISTERS Center for Transgender, Glory Hut Foundation, M-Plus Foundation and RSAT. The manual has been reviewed by the Bureau of AIDS, TB and STISs, the Department of Disease Control Thailand (DDC), and the Wednesday Society. The Thai Red Cross Anonymous Clinic reviewed the content pertaining to ARV treatment. As the author, the PSI Thailand Foundation appreciates all the support that has been provide in developing this manual and expects that the manual will be useful to care and support providers.

PSI Thailand

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Introduction

Community-based care and support among men who have sex with men and transgender individuals living with HIV.

Everyone diagnosed with HIV faces a range of concerns, which may include on-going health, whether to disclose their status to partners, and HIV/AIDS-related stigma and its consequences, such as loss of employment or home. Men who have sex with men (MSM) and transgender individuals (TG) who learn they are HIV positive face double stigmatization from HIV positive status and the disclosure of same sex behavior. Access to community-based care and support services can help MSM and TG identify and work through some of these issues.

Fear of discrimination and stigma cause many MSM and transgender people to postpone or decline seeking medical care. Others, once in care, withhold personal information that may be critical to their care. Clinical environments can be very threatening to MSM and transgender people when presenting with anogenital symptoms or being asked questions related to sexual behavior. Undisclosed behavior, especially anal sex and symptoms lead to poor clinical care by the clinician and poor health outcomes for the patient.

Moreover, clinical service providers often fail to ask about male-to-male sexual behavior due to negative attitudes toward same sex behavior, pre-conceived notions about a client's behavior and identity, or out of fear of asking sensitive questions.

Sexual Identity and behavior of men who have sex with men

The term *men who have sex with men* or *MSM* is meant to address all men who have sex with men, regardless of their sexual identities. Only a minority of men involve in same sex behavior self-define as gay, bisexual or homosexual. They do not consider their sexual encounters with other men in terms of sexual identity or orientation. Many men who have sex with men self-identify as heterosexual rather than homosexual or bisexual, especially if they also have sex with women, are married, only take the penetrative role in anal sex, and/or have sex with men for money or convenience.

MSM includes various categories of men who may be distinguished according to the interplay of variables such as:

- their sexual identities, regardless of sexual behavior (gay, homosexual, heterosexual, bisexual, and transgender, or their equivalents, and other identities);
- their acceptance of- and openness about- their non-mainstream sexual identities (open or closeted);
- their sexual partners (male, female, and/or transgender);
- their reasons for having these sexual partners (natural preference, coercion or pressure, commercial motivation, convenience or recreation, and/or being in an all-male environment);
- their roles in specific sexual practices (penetrative, receptive, or both); and
- their gender-related identities, roles and behavior (male or female, masculine or feminine/effeminate, cross-dressing or gender-concordant dressing).

Sexual Identity and behavior of transgender individuals

Transgender is a broad term that designates somebody who does not fit clearly into “male and female” descriptions. The individual rejects the gender assigned to him or her at birth. Like MSM there is a broad diversity of transgender individuals who may also be distinguished according to the same interplay of variables as MSM. Perhaps the two most noticeable sub-groups are transvestites and transsexuals.

A transvestite is someone who enjoys or feels compelled to dress as the opposite sex. This could be because they would like to be women- but more often it is a temporary ‘role play’ that is usually but not necessarily sexually charged.

The term transsexual refers to an individual who feels that their gender identity does not match the biological body he or she was born with and/or the gender he or she was assigned by society. They feel that they were born in the wrong body – men who feel that they should have been born women and vise versa. Someone whose heart and brain are telling them that they really belong to the opposite gender. Transsexuals can be referred to as male to female (MTF) or female to male (FTM). Transsexuals are further described in terms of their stage of transitioning to the opposite gender, whether they are “pre-operative”

(“pre-op”) or “post-operative” (“post-op”) and some describe themselves as “no-operative”(“no-op”).

Community Based Organization

While outward discrimination is not apparent, there is a fear of social sanction inhibits disclosure of sexual identity, behaviors, and HIV status. Disclosure, when and if it occurs, is most often limited to a group of people with whom a MSM or TG has a close relationship. It is therefore important that MSM and TG have access to appropriate or ‘friendly’ HIV and STI related services where they can obtain accurate information about HIV (and STI) transmission, prevention and personal health care and be guided through the maze of care and support services.

Men who have sex with men and transgender, like other clients who have tested positive for HIV, will need information on health, rest, exercise, diet, safer sex and infection control. Follow-up counseling visits may be necessary to answer further questions and to assess the impact of the diagnosis on the client’s relationships, occupation, sexual behavior and living situation. Special attention should be given to problem solving in each of these areas. Because many health services do not have the time or staffing to provide individualized services and/or have traditionally not been welcoming of MSM a number of community-based organizations (CBO) have been established to fill the gaps in programming, information and services. Some of the better known MSM and TG run and oriented CBOs include the POZ Home Center in Bangkok, SWING, Sisters, CAREMAT, M Plus+, Glory Hut Foundation, The HIV Foundation of Thailand, Rainbow Sky Association of Thailand.

These CBOs are staffed by knowledgeable, experienced, dedicated and more often than not experts, volunteers. (Varuni 2549) The CBOs better understanding of the information, psychosocial and services needs of MSM and TG, thereby providing opportunities for the CBOs to work as a liaison, case management, unit between the MSM and TG clients and various governmental and non-governmental organizations and services.

Case management

Case managers are persons trained in assessing the needs of the clients and providing aid accordingly by liaising, follow-up monitoring and evaluating to protect the rights of the clients. (Kittifat, 2553) CBO case managers are usually volunteers who are trained in all aspects of care and support service provision, inclusive of assessments, planning, follow-up of clients attendance to services, and reporting of sensitive information to health care providers with the consent of the client. These case managers have an advantage over hospital-based case management services due to the same-sex orientation of the CBOs. The case managers are thereby able to deal with client issues in a non-judgmental way, using neutral or supportive language and appropriate non-verbal behavior to elicit a client's health and sexual history. In addition, the case managers are able to:

- Screen for issues such as internalized homophobia, sexual dysfunction, sexual violence, and suicide ideation;
- Assist clients in identifying safer sex strategies, and other risk reduction strategies related to drug and hormone/steroid use, among others, that will be both pragmatic and effective, and;
- Provide guidance and support for adherence to treatment for sexually transmitted infections (STI) and anti-retroviral (ARV) treatment for HIV.

A single meeting between the client and case manager is not sufficient to explore all the issues. Continuous follow-up is necessary. Where it is not possible in clinical services, CBOs are strategically placed to provide the needed support and assistance.

This document has been developed to guide the MSM and TG oriented community-based organizations, and especially the case managers, in the provision of care and support services.

Chapter 1

CAP-3D Model for community care & support of MSM and TG

CAP-3D Thailand is an HIV control and prevention program, to improve access to HIV testing and counseling services care and support to help clients access to CD4 cell count, access to Anti-Retroviral (ARV) treatment and support for ART adherence.

Care and support is holistic care (covering physical mental social and spiritual wellbeing). It is a service that aims to help clients receive continuous treatment. Service provision starts from a client's needs assessment, then planning, before care co-ordination and continuous follow-up to assess whether the services meet the client's need or whether the client's needs have changed.

Care and support covers 5 steps in the cascade of HIV prevention and treatment

- STEP 1- HIV Testing and Counseling (HTC)
- STEP 2- Care and support (services provided by case managers to both HIV positive and HIV negative clients)
- STEP 3- Getting CD4 testing
- STEP 4- Access to Anti-Retroviral (ARV) treatment
- STEP 5-Support for ART adherence

The above 5 steps are to provide clear path to plan and implement care and support for case managers Although the timeline for steps may differ for each client, the order of steps remains the same. Care and support means providing regular care and support to clients in a holistic way, which includes assessments, planning, and implementing the plan.

The aim of care and support services

Care and support services by CBO use a holistic health approach, which means that the services are not compartmental, covering only physical or merely emotional/social support. Care and support services consider health as a single unit that has 4 dimensions: physical, emotional, social and spiritual health; these variables are interconnected and affect a person. Therefore, care and support service provision always needs to cover all the 4 dimensions according to the client's needs and for the improvement in his or her quality of life. A person's quality of life means that he or she can lead a meaningful life, have self-value, and can be connected with other people in the society (Kannika and Panas 2555). Therefore, case managers need to understand what client needs in all 4 dimensions of health in order to support their wellbeing (diagram 1).

What is needed for PHIV health?

Diagram1: What PHIV needs to complete their wellbeing (FHI360, 2012; Weatherburn P et al., 2009)

Findings from research show that common needs concern quality of life rather than practical problems. PHIV remain unhappy due to unmet needs in sexual pleasure, anxiety/depression, sleep disturbances and decreased self-value. Widespread experience of discrimination and social isolation points to particular hardships for PHIV, in comparison to other chronic conditions. Health and social care staffs are common perpetrators of such discrimination. These factors in turn results in poor quality of life (Weatherburn P et al. 2009).

PHIV may not receive services that meet the needs illustrated in diagram 1 in hospital or clinical settings. The reasons vary from a lack of understanding of the special needs, insensitivity and, in fact, outright hostility towards MSM and TG, lack of funds, personnel, knowledge etc. This is where CBO case managers have an important role to play.

The case manager provides care and support as a friend, not as institutionalized health care provider. Normally, the work of the case manager starts with letting clients tell their story. The case manager listens to the client's needs, which allows the clients to know that they are not alone. They have someone who cares and is ready to help. The case manager plays a role of companion who helps the client explore his or her past, so case manager helps clients think and plan their future, to help them meet their needs in all 4 dimensions

- Physical wellbeing: case managers support clients in access to the needed medical services; provide knowledge in safety measured to prevent STIs
- Emotional wellbeing: case managers help clients cope better with their incurring problem, thus, minimized clients' anxiety and depression
- Social wellbeing: case managers help clients return to their normal social activity with partner, family and friends
- Spiritual wellbeing: case managers help client to love and forgive one self and others, to live a meaningful life

Working Principal of Coordination in Care and support

To meet the holistic objective of meeting PHIV needs in care and support, the services have to include the following components.

Assessments of clients' needs and state of readiness in addressing those needs and problems with a client centered approach, this should include client's thoughts about the his health problems, the clients should be asked and allowed to narrate his life. Listening to the narrative usually helps in assessments of problems and needs of the client.

- Simple questions that can be used to ask so case manager can learn about client's suffering are:
    - What's your idea/feeling towards he problems;
    - How has the illness affect your normal function (eating/sleeping/activities) or work;
    - What's your expectation from the treatment/care?

The answer would help case manager to tailor the services to match with each client's different context (Levenstein, J.H., et al 1986; McWhinney, I.R., 1997; Saipin, 2002)

Planning on the care and support that will be needed and service provision

Planning

Client needs, expectations, attitudes, problems, feelings, stage of illness all are needed inputs to plan care and support strategies. Individualized strategies will be needed for each client. Case managers apply the client centered plan, where clients are decision makers themselves, case manager's works as a friend who is helping the client to think not a decision maker.

- Case managers help client think by questioning, using open-ended question to make them think and actively listen to client's ideas, feeling, and expectations.
- Then, reflect those ideas, feeling and expectations

By questioning, active listening and reflecting, clients will better understand about themselves what they need in life and what they need to do in order to achieve those goals. Sometimes, case manager could also guide on the options that clients' have, and clients would eventually be able to make a decision on a relevant choice.

Care and support service provision

2.1 Case managers' care and support services include being the liaison between hospital and client or between governmental agencies and the client.

2.2 Case managers aids clients in accessing the services they need from health and social care providers, such as changing the registered hospital in NHSO scheme

2.3 Case managers act as a friend of the client and accompany him/her on clinical or hospital visits or visits to other agencies providing care and support-related services. This helps in minimizing clients' frustration, and improves their spiritual wellbeing, by being supported.

1. **Evaluate the results** from the services provided. Are the services meeting with the client's needs and expectations? If not, explore what were the barriers, and how the services can be improved

2. **Modify or change the plan** according to the evaluation outcomes and the needs of individual clients.

Communication Skills needed for care and support on the prevention and treatment of PHIV

From the HIV prevention and treatment cascade, the direction of the care of support services is clear in that client needs to modify their behavior in order to have an improved health outcome. For example, clients entering to HIV testing and counseling services in step one need to be well informed about the route of transmissions and behavioral risk that leading to the transmission. Then after knowing the result of the test, whether or not the result is positive or negative, they will enter to the second step, receiving care and support.

For those whose test result remains negative, they need to receive care and support in order to prevent infection with STIs or encounter other health risk. For those who have been diagnosed HIV positive, they need to receive care and support in order to reduce their fear and anxiety, to be better informed, and to receive help in access to medical treatment and social services. They will get accesses to CD4 cell count and consideration for ARV treatment, in step 3 and step 4 respectively. Eventually, in step 5, when they need ART, case manager will provide them with support to enable them to have a good treatment adherence.

Case manager must be trained to have adequate communication skills to help guide the client through each step. Therefore, case manager needs to have skills to motive client to help them progress, to help them change their behavior, so the risk of additional infection will be reduced. Case manager needs to support them to be motived to take care of themselves, to enter to treatment services, to continuously go for the follow-up services, and to take their medicine correctly and continuously. The communication skills needed for this is known as Motivational Interviewing (MI).

Motivational Interviewing

Motivational interviewing is a client-oriented goal directed counseling which motivates client towards behavioral change. Case manager helps client explore their own ideas, feeling and expectation, by using open-ended questions, active listening, reflection, which enable client's

to explore their ambiguity towards change. Case manager also plays an important role in making client move towards positive change. By questioning, positive attitudes are identified through their answer, case manager then affirm the clients by reflection of those positive words and ideas that is initially clients said themselves.

Spirit of Motivational Interviewing (MI)

1. **Evocative/Eliciting skills:** Case manager uses questions to evoke clients to think and elicit their positive thought, so they tell case managers their ideas, in which they simultaneously hear their own positive words and thought. This thought would further make them moved forward for an improvement.

2. **Collaborative:** Case manager and client collaborate as equals to understand the problems of clients then case managers can help to solve, the operating word is "help to solve" not solve.

3. **Autonomy:** Clients have their autonomy to make decision.

Motivational Interviewing involves "self-perception theory" where clients explore their own thought, overcome the barriers they see, and then move towards self-change. Motivation interviewing help the clients hear themselves, and learn more about themselves like the phrase ***"when I hear myself talk, I learn what I believe"****. Hence the interview (counseling) help them teach more about what they belief, what is the goal of their life, and find the way to improve themselves* (Miller, W.R., & Rollnick, S., 2002; Pichai,, 2010).

Motivational interviewing is a communications strategy that help clients hear, review, and appraise their own thoughts by using 4 main skills with the acronym **OARS**:

1. **O** for **open-ended question** to induce Self motivational answer/*self-motivational statement(SMS)*
   For example: Case manager: *What is the most important for you?*
   Client: *I would like be successful to make my parents proud of me. (Self-Motivational Statement: SMS)*

2. **A** for **affirmation** to support clients on their thought to improve self-confidence on their good thoughts or what they are had already done.
   For example: Case manager: what is the most important for you?
   Client: I would like be successful to make my parents proud of me. (SMS)
   Case manager: *You do have a good heart, aiming for success to make your parents happy.*

3. **R** for **reflective listening** to repeat their own thought, helping them hear their own voice and motivation, under (Self-perception theory).
   For example: Case manager: what is the most important for you?
   Client: I would like be successful to make my parents proud of me. (SMS)
   Case manager: *You want your parents to be proud of you.*

4. **S** for **summarization** to highlight important thoughts along the counseling session and to repeat their self-motivational statement and enhance their willingness to change. For example:
   Case manager: *today we have been through a lot of conversation and I would like to summary important points. You said that you will take care of yourself to enable you to pursue the goal of your life that is to be successful and make your parents proud of you.*

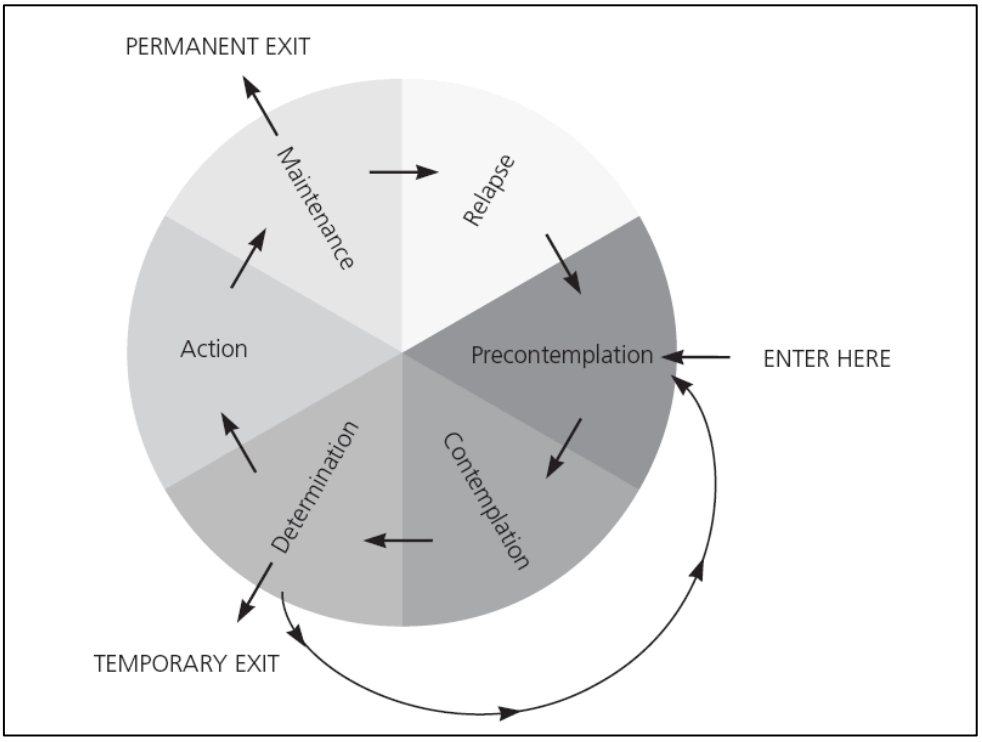
Assessment of awareness and readiness for behavioral change

In care and support services provision, case manager needs to assess clients' awareness about their problems. Behavioral change awareness and readiness must be assessed by case managers; two layers of assessment are used

1. Risk behavior assessment
2. Awareness about the consequence of behaviors.

The assessment is based on the stage of change model which is proposed by Prochaska and DiClemente (Prochaska,O. & Velicer, W.F., 1997). The model of change process contains six steps following:

1. Pre-contemplation.
2. Contemplation.
3. Determination / preparation.
4. Action.
5. Maintenance.
6. Relapse.



The Stage model of the process of change Prochaska and DiClemente.

1. **Pre contemplation**: In this stage Clients are unaware of the problems they don't think that their behavior is related to the risk of having problems or poor health outcomes.

   Case managers' **suitable response for clients at pre-contemplation stage is <u>providing feedback</u> and/or information (knowledge)** to help them learn about their own risk and problems. Normally, the feedback is preferably since it does reflect the client's own experience (self), which raises awareness better than giving general information.

   For example: *"The difficulty in the urination was related to sexually transmitted infection you have because you didn't use condom every time you have sex."*

2. **Contemplation:** Clients begins to contemplate behavior change. They are aware of this behavioral risk, but remain ambiguous if they should change since they still perceive the benefit of the present behavior, whilst worried that it could cause negative consequences.

Case manager should **response to clients at contemplation stage using pros & cons strategy** that is helping clients to explore the risk and benefit of changing and not changing, like in the example table below. Case manager needs to explore all the four aspect not simply questioning about the pros of using condom and the cons of not using condom. Otherwise, the clients would feel that case manager is biased and does not really understand the clients.

For example: *"how would your life be if you change?" and "if you don't change how would it be?"*

"*What are the pros and cons of each choice?"*

behavior	pros	cons
Present behavior: inconsistent use of condom		
Expected behavior: using condom consistently		

3. **Preparation/Determination:** Client decides to change, so they start searching for information and prepare.
   Case manager should **provide clients with options and supporting on their decision**. Sometimes, case manager helps by giving list or menu of options that the clients have and ask them to make their own choice. Client should not feel obliged to make choice, but should feel that they have freedom to make choice and changes depends on one owns' responsibility. After the client's decision, case manager should be supportive and make them confidence that they are capable to make changes (support their self-efficacy).

4. **Action:** Client acts and experiment behavior change. This stage is when clients start their action experiment new behavior in which they might be easily tempted with certain stimulus. Normally this stage is during the first 6 months after starting new behavior.

   Case manager should be supportive, **assess on the compliance and adherence** of the new behavior, and ask if there is obstacle for continuing the new behavior.

5. **Maintenance:** Client maintains the change that is they continue having new behavior long period i.e. longer than 6 months. However, they could return to previous behavior if there is something that triggers them.
   Case manager response for clients who are at this stage is to ask them what they think are factors that could trigger them to return to previous behavior. How would they deal with it in those circumstances? **(Relapse should be prevented by avoiding triggers)**

6. **Relapse**: Client may relapse back to old behavior, particularly in when they are vulnerable. Relapse is in fact normal in the cycle of change, but this doesn't mean that the client could not pass to an improvement stage again. Clients at this stage need support and encouragement to help them build up their confidence to make changes again.

The Stages of change model and Motivational Interviewing, proposed by Miller& Rollnick could be applied to various behaviors (Prochaska, J.O, & Velicer, W.F. ,1997 ; Pichai, 2010)

For CAP-3D care and support model for prevention and treatment of HIV, the stages of change and motivational interviewing skills could be used to help assess and motivate clients who are reluctant to get HTC services. The clients' unawareness of their health risk could be raised by providing feedback about their health risk and by giving new information.

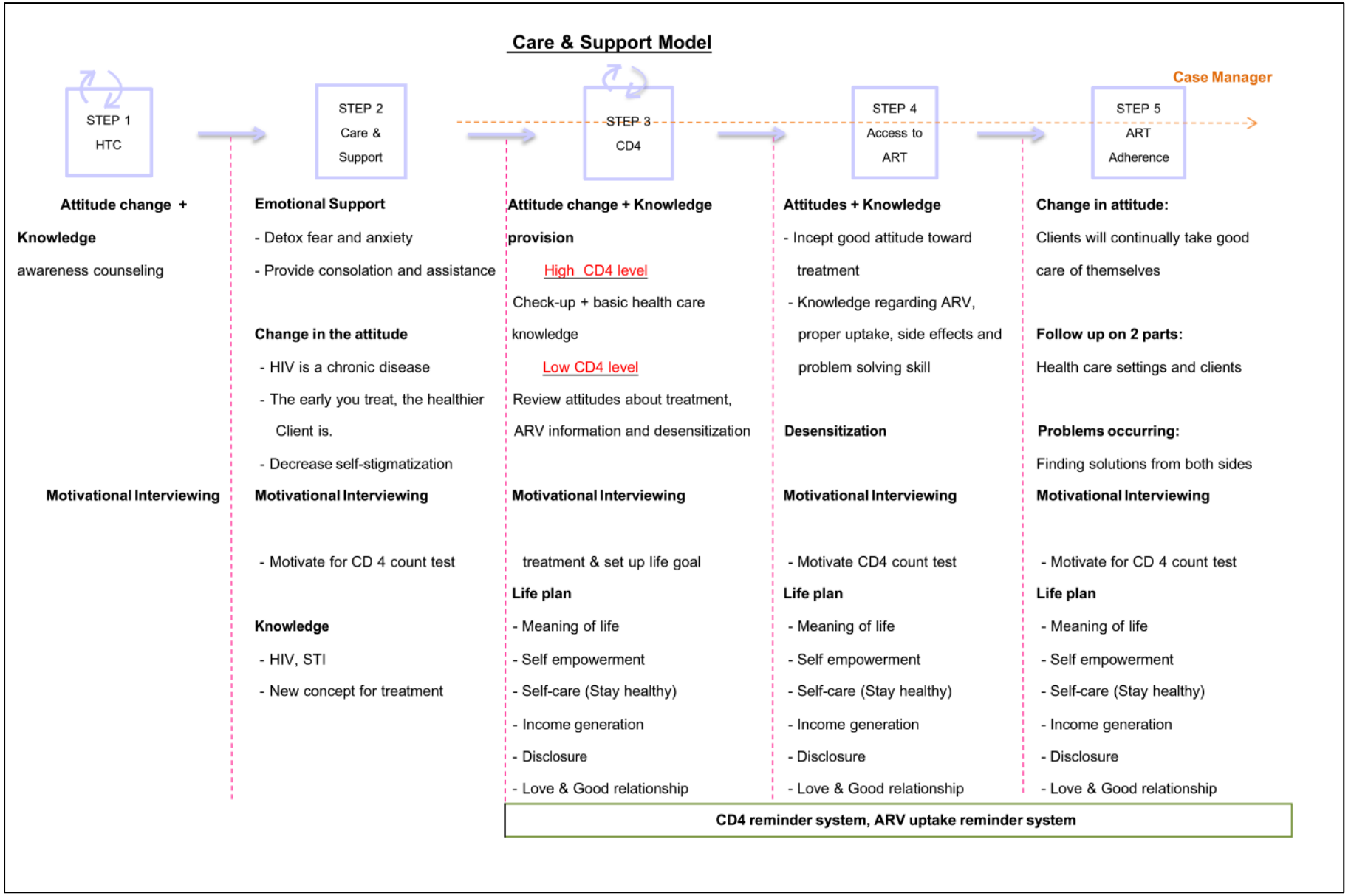
When clients are reluctant to change, exploration of their perception towards pros and cons should be used to help them move forward. Stage of change assessment and motivational interviewing skills can be used help client be motivated to get CD4cell count, to enter to treatment, to explore the ambiguity on taking ART and to support them for ART adherence.

Normally, assessment of the stage of change should be applied to the following behavior

1. STI prevention through condom use.
2. Stop or limit the use of psychoactive drugs and substances, including alcohol.

3. Stop needle sharing among persons with injecting drug use (PWID) and hormone/steroid injectors.
4. Testing for CD4 count.
5. Start ARV treatment.
6. Adherence to ARV treatment regimen.

Details of the steps for behavior change are in the respective chapters of this guideline.



CAP-3D Care & Support Model for the prevention and treatment of HIV

Relationship between case manager and client

There are 3 states of human personality according to the transactional analysis in counseling (Pongphun, 2000)

1. Child ego state
2. Adult ego state
3. Parent ego state.

Early phase after clients gets to know their HIV sero-status their behavior is akin to a child, in which case manager might act as parents teaching, advising, taking decision for client; however, this will be useful only for short terms. The disadvantage of this relationship is that it will make the client be dependent and lack of self-confidence to stand on their own and belief in their autonomy on their decision-making. Hence, case manager appropriate positioning is important from the beginning to help the client grow (psychologically) and make them be able to have appropriate reasoning. Therefore, they will be able to think critically, be able to solve their problem on their own and ultimately be independent and look after themselves.

Adult ego stage is the most suitable positioning between case managers and client in the long term. That is they have mutual respect between each other and are able to rational.

Ethics and standard for care and support practice.

Case manager needs to be ethical, respectful and honest to their clients through care and support services provision Case manager needs to have needed competency for care and support work, respect their clients, be thoughtful and do no harm.

Ethics:

1. Case manager has to work with honesty and integrity.
2. Case manager has to respect rights of clients.
3. Case manager has to respect and protect client's dignity.
4. Case manager should not discriminate or have any hostility towards client.
5. Case manager should not take decision in place of clients.
6. Case manager will not advertise about skills they do not possess.
7. Case manager should be able to be self-aware about their skill set level will refer client to a better equipped person in case a need arises.

Standard:

Standard for case mangers

1. Work with full understanding of client' sensitivities and respect human rights.
2. Work with full integrity and fairness regardless of client's social, economic status.
3. Work without discrimination.
4. Protect client's confidentiality at all time.

Confidentiality:

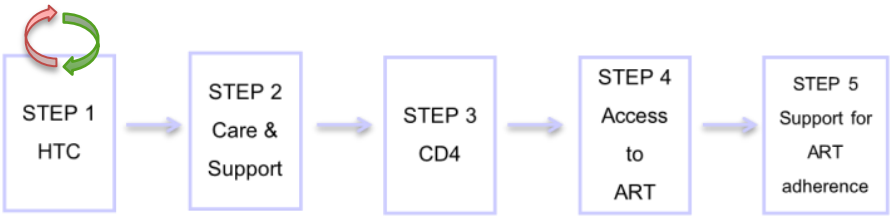
Case managers will need to collect client's data during the provision of care and support services. These are confidential data should be kept safe and secure at all times, the following are to be followed at all times.

1. All identification data of client's must be stored in a secured place.
2. Written consent must be obtained in case of sharing data with health officials for treatment purpose or any other purpose.
3. All case managers will be briefed and trained about client's confidentiality before they start their jobs.
4. All case managers will sign the oath of confidentiality (annex 3)
5. Never ever photograph clients.

From now on each step for care and support in the HIV prevention and treatment cascade is explained in each separate chapter. The information is a synthesis of experience and data collected over the years by all the CBOs and NGOs.

CHAPTER 2

Attending HIV Testing and Counseling Services



STEP1: Attending HIV testing and counseling (HTC) services

CAP-3D model of community care and support for HIV prevention and treatment starts with step 1 which is motivating clients to attend HTC services. In this step, the activity is not only about getting client test and let them know their HIV status, but it's also important opportunity for health promotion and prevention of STIs and modification of other health risks. Therefore, a lot of the case manager's tasks here involve the assessment of the client's health risk. Case managers are required to assess client sexual and other behavior that may place him or her at risk of HIV infection.

Risk behavior for HIV infection include

1. Unprotected sexual contact: not using condom or using one incorrectly
   - Alcohol and/or psychoactive drug use before sexual contact
2. Share needles such as among persons with injecting drug use (PWID) or MSM/TG injecting hormones/steroids or cosmetics (i.e. Botox)

Case manager should act as a friend or a pal and counsel on risk behavior change after detailed data collection through friendly talks and discussion. The discussion towards sexual behavior should include recent risk behaviors. The details about an at-risk event may be collected by asking questions open-ended questions, such as: How do you protect yourself from HIV/STI when having sex? What obstacles do you have in using condoms? What are some thing you do that make you in the mood or feel more comfortable before having sex? (e.g. drugs and alcohol) How do you use ___ (drug)? How often do you share injecting equipment with others? How do you feel about your drug and alcohol use? Addiction could

be screened using CAGE questionnaire (shown in the knowledge section) what were the client's preventive measures? Were condoms used?

Once sexual behaviors have been revealed, HIV risk can be determined through the Four Principles of HIV Transmission - "Exit-Sufficient-Survive-Enter" (ESSE). Exit is HIV needs to have exit from a human body to transmit. Sufficient is that there needs to be sufficient amount of HIV in the body fluid to transmit from one person to another. Survive is that the environment needs to be suitable for the survival of HIV. Enter refers to the entry point where HIV enter to another human.

Case manager should help the client to change their behavior in order to reduce STIs and HIV transmission. To help the client change their behavior, after knowing which behavioral risk the client's take, case manager should assess their awareness of the risk using the stage of change model. Then motivate them to change their behavior through motivational interviewing. An example of interview for each stage of change is shown in following table: motivational interviewing to help client change their sexual risk behavior to prevent STIs.

Table: motivational interviewing to help client change their sexual risk behavior

STAGES OF CHANGE	STAGE SPECIFIC COUNSELING STRATEGIES		
PRECONTEMPLATIVE STAGE **Client sees no need to practice safer sex** *"There's no way I need to worry about safe sex"*	**Story Telling:** Tell client a "success story" that highlights similar obstacles to change and potential solutions.	**Information giving:** Specific to the client's situation ✓ *What do you know about…?*	**Discuss impact of behavior on others** How behavior is negatively impacting on their health
CONTEMPLATIVE STAGE **Client sees the benefits of practicing safer sex but is still hesitant to change** *"Yes, I worry about unsafe sex but…"*	**Explore ambivalence / Offer substitutes:** Help client see why s/he is "on the fence." ✓ *It seems that you enjoy taking drugs but you are anxious that you have unsafe sex when intoxicated. What difference would it*	**Discuss pros & cons:** Explore the client's costs and benefits of change. **Offer substitutes:** Harm reduction options. ✓ *E.g. not mix alcohol / drugs*	**Discuss behavior in relation to self-image:** ✓ *Working to help your family / get an* **Increase self-efficacy:** ✓ *You gave up smoking so it seems you can make difficult*

DETERMINATION / PREPARATION STAGE **Client is ready to practice safer sex and may already be trying safer sex.** *"I want to prevent reinfection with HIV and*	**Getting started / Planning:** Help the client to plan to accomplish the behavior change ✓*E.g. Client aims to buy or obtain free*	**Build self-efficacy, confidence, practice skills and establish a first step:** ✓ *Client demonstrates*	**Support and referral:** Increase access to prevention tools and services by referral ✓*Provide information on*
ACTION **Client is implementing safer sex.** *"I carry and use condoms."*	**Continued support:** Counselor, friends ✓*Role play asking for condoms in different situations*	**Find substitutes:** When partners refuse condoms ✓ *Negotiate for and practice*	**Follow-up:** Follow-up on client's experiences ✓*Acknowledge successes.* ✓*Problem solve*
MAINTENANCE STAGE **Client anticipates triggers for relapse and coping strategies.** *"I can anticipate what may happen and prepare myself*	**Recognize relapse as part of change process:** Assist client in identifying possible **Identifying rewards:**	**Find substitutes:** When condoms are not readily available or partners refuse their use ✓ *Negotiate for*	**Identify supports:** Help client identify peer support ✓*Who has experience and* **Become a role model:**
RELAPSE **Client may have had a time when they didn't use a condom** *"I forgot to use a condom this time but…."*	**Recognizing what lead to relapse:** Help client identify and understand circumstances that lead to lapse.	**Highlight triggers/barriers that lead to lapse:** Review plan and encourage confidence that	**Review & modify plan:** Identify what has worked and what has not ✓*A lapse doesn't*
TERMINATION	**Client is 100% confident in all trigger situations.** **Congratulate the client and again remind him or her that you are available for**		

Adapted from Readiness for Change Tool: What to do with patients at risk of HIV and STIs (2006) South Eastern Sydney ILLAWARRA, NSW Health

Case managers have a role under three situations.

1. HIV negative
2. HIV intermediate or inconclusive
3. HIV positive (The role of case manager when HTC result is positive will be explained in the next chapter)

STEP1: Getting HIV Testing and Counseling

HIV Test Result: Negative

Case managers should counsel and increase awareness about sexually risk behavior in clients, advise clients on prevention of HIV infection. Mainly case managers must follow-up clients and motivate them to have an HIV test every 6 months or, in high risk cases, every 3 months.

Case manager could increase client's awareness towards health risk behavior by providing feedback on how their risk behavior has affected their health. Information towards health risk can generally provide through two means. One way is giving general knowledge about risky behavior and the effects of behavior on health. Another means is providing feedback, using specific information, to get the client to reflect how his or her behaviors have affected their health. The second means is generally more effective in raising client's awareness, since the client has experienced the consequences of by his or her behavior.

Case example: Somchai got HIV test because he was diagnosed with Gonorrhea. HTC result was Negative.

Thus, case manager can provide Somchai with knowledge about STIs and prevention of STIs.

There are 2 ways of giving knowledge:

1. Giving general information: "using condom can prevent you from HIV infection and other STIs"
2. Providing feedback: "This time you got gonorrhea because you were reluctant to ask your partner to use condom"

STEP1: Getting HIV Testing and Counseling

HIV Test Result: Inconclusive or intermediate

In cases with inconclusive HIV test result case managers must explain the meaning in simplest of terms to the client, this includes the following:

1. Window period.
2. Auto immune diseases which can cause False positives e.g. Systemic Lupus Erythematous (SLE), Sclerosis
3. Viral infection with production of Antibodies similar to HIV' Antibodies. E.g. Herpes simplex, Bird flu.
4. Vaccines during one month prior to HIV testing e.g. HBV vaccines.

Furthermore and equally important case manager should make sure clients are fully aware of risk behavior and avoid risks. **The current scheme for inconclusive result is to retest at 2 weeks and/or 1 month and/or 3 months**.

Periods during which clients have to wait can usually do cause anxiety in clients. Case managers need to allay the fears and anxiety. If clients are very anxious then Nucleic Acid Amplification Test (NAT) can be advised. Anonymous clinic at HIV-NAT Chulalongkorn Bangkok currently performs NAT anonymously and least costly.

Care and Support services provision for clients getting HIV Testing and Counseling (STEP1)

Case managers providing service to the client must perform the following task.

1. Allay fears and anxiety
2. Assess the risks of HIV infection, using ESSE methods as described in the following section (essential knowledge for care and support). Provide clients with knowledge in HIV/STIs prevention.

3. Assess client's readiness for change, using the stages of change model (as described in chapter 1 and the examples from the table in this chapter). Motivate clients to change their behavior using motivational interviewing relevant to stage of the client's readiness for change.

   For example, if client's perception towards their behavior is considered as being in pre-contemplation stage, case manager should providing feedback and information to help them aware about the problem. Meanwhile, clients who are contemplated, case manager should help them balance the between pros and cons of remaining the same with having risking behavior and pros and cons of changing to a new behavior.
4. Providing clients with the information about their legal right to access and receive care according to the National Guidelines (NHSO, 2013).
5. Explain the client about the HTC follow- up frequency. Client should attend HTC services every 3-6 months depending on their level of risk. There should be a record on when the client has received the test and their next appointment for follow-up.
6. All sessions are recorded in writing. The recorded should be provided for both the clients and case managers, so case managers could check the information on when they need to call in order to remind the clients the next HTC.
    a. However, the records for the clients to remind themselves should be noted as general information such as a noted on 3rd March 2015, "Next health check up in the first week of September", instead of "Next HIV test in 6 months" or "HIV test every 6 months".
    b. Case manager should have a note to remind themselves to make a call to provide care and support to the clients, making one day later than the real appointment that has been made
        i. On the 4th November 2014: "follow up Mr. X Tel……"
        ii. On the 4th March 2015: "follow up Mr. X Tel…… to repeat HTC"

2nd month follow up: case manager make a call to ask about their lives their wellbeing to keep the connection between case manager and the client, to keep contact, to assess the progress on behavioral change to prevent HIV/STIs and their health problem during the previous month before the call

4th month follow up: case manager should initially ask the clients for the reason of their call, if they know why case manager call them. The reason for the call is in fact to check if the established reminding system remains intact. Then, case managers should ask the client's if

they had planned to repeat the test. Case manager should also ask their clients if they need the case manager support by accompanying them to the health and social services. If the client needs the case manager to accompany, the case manager should accompany the clients. If the clients are able to get HTC services by themselves, follow up HTC result could be through a telephone call.

7. Case managers explore alternate methods of follow up and communication e.g. LINE, Facebook

8. In case of another “Negative test result or inconclusive” case manager restarts the cycle.

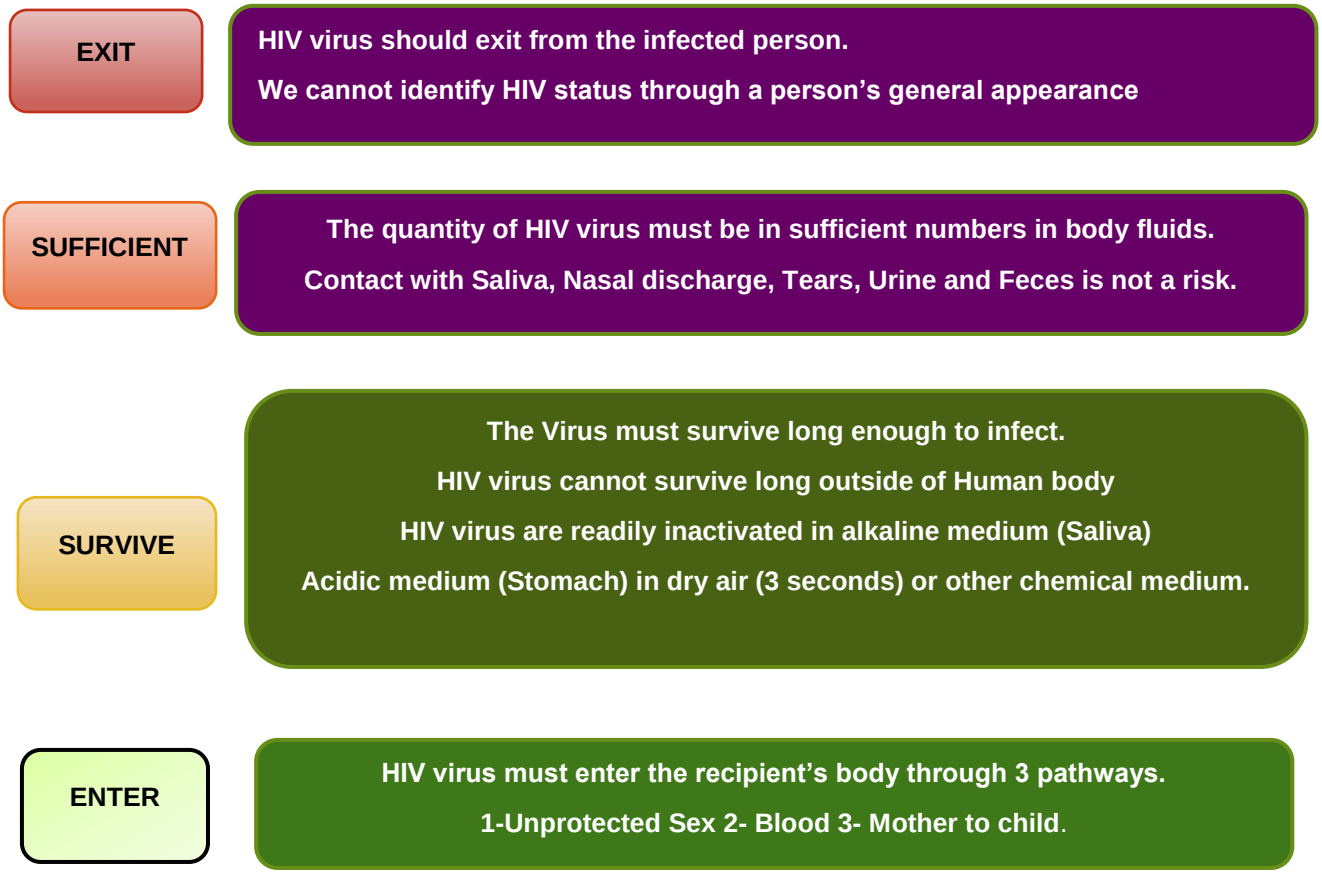
Thai National guideline to HIV Testing	
HIV Testing	**Every 6 months.**

Essential Knowledge for case managers

Assessment the risk of HIV transmission

Exit-Sufficient-Survive-Enter (ESSE) principle

ESSE assessment helps to assess risks for HIV transmission. HIV transmission relies on of 4 factors. First, there needs to be an HIV exit from an HIV infected person to another. Second, the amount of HIV in the body fluid needs to be sufficient needs to be sufficient. Third, in order to transmit HIV needs to transmit through setting (environment) that enables HIV survival. Fourth, there needs to be an entry point.



The four components are needed for the assessment of HIV transmission

The above chart is used to evaluate the Risk to HIV infection and can be considered into 3 categories (as shown in the table below.

1. High Risk behavior
2. Medium risk behavior
3. Low risk behavior

Though some behavior does not get the client infected with HIV but clients can get infected with other organism such as Human Papilloma Virus (HPV).

Care and Support to prevent HIV infection:

Common risks of HIV infection among MSM/TG are:

1. **Unprotected sex:** Having sex without using condoms is the most common reason for HIV infection among MSM/TG.

The following two charts are developed based on the data from (FHI360, Positive Health 2012).

Table: Risk of HIV infection and STIs through different routes

Type	HIV Infection risk	STI risk	Examples of STI
Oral sex	**Low**	**High**	**Herpes, Gonococcal pharyngitis, Syphilis Gnorrohea**
Sex with finger	**Low**	**Low**	**Molluscum Contagiasum**
Vaginal sex	**High**	**High**	**Herpes, lice, scabies, genital warts, gonorrhea, chlamydia, hepatitis B, hepatitis C and syphilis.**
Sex through Neo vagina	**High**	**High**	**Herpes, lice, scabies, genital warts, gonorrhea, chlamydia, hepatitis B, hepatitis C and syphilis**
Anal sex	**High**	**High**	**Herpes, lice, scabies, genital warts, gonorrhea, chlamydia, hepatitis B, hepatitis C and syphilis**

Table: Level of risk for HIV transmission according sexual behavior and drug use.

No risk	Low risk	Medium risk	High risk
Deep / French kissing			Unprotected anal sex without ejaculation
Mutual masturbation	Anal sex with a condom [1]	Unprotected sex, ejaculation outside the anus or vagina	Unprotected anal sex with ejaculation
Fisting without a glove[2]	Vaginal sex with a condom	Unprotected vaginal sex (risk to man)	Unprotected vaginal sex (risk to woman)
Oral-penile sex with a condom	Oral-penile sex without a condom		Double anal penetration, with or without condoms.
Oral-anal sex (rimming)	Oral-vaginal sex without a barrier (e.g. dental dam)	Group sex with condoms[3]	Group sex without condoms[2]
Genital rubbing (frottage)		Multiple user sex toys	
Body licking	Stimulation with fingers	Trick sex[4]	
	Urinating on partner (Watersports	Spraying semen on face (Facial)	Sharing contaminated needle and syringe

1 Condom use means using condoms that are in good condition – no broken or have holes, not expired – correctly with water-based lubricant.
2 Fisting is low-risk for HIV infection but it may increase the risk of other activities that may follow, e.g. the risk of unprotected anal sex will increase after fisting.
3 More information is needed about what sexual (and/or drug use) behaviors are practiced in the orgy, oral-penile, oral –anal, fisting, penetrative anal sex, drug use, including alcohol and poppers, etc.
4 Trick sex may include inter-femoral sex (penis between the thighs) or armpit sex.

Behaviors which add up the risks to HIV transmission through sexual contact include the following factors:

- Alcohol drinking before sex
- Narcotics use before sex.
- Sexual stimulatory medicine use. (Viagra)

2. Substance Abuse

Narcotic is another common mode of HIV infection because narcotic use causes the person to lose self-control, situational control. This result in HIV infection through use of shared injection needle and or losing self-control and have unprotected sexual contact.

Table: mode of drug use and risk for HIV transmission

Modes	Risk factor
Injection needle	- Blood is drawn - Needles have hollow core where virus resides.
Method of injection	- Intravenous injection or sometimes mixing blood and drugs and reinjection.
Syringe and needles	- Blood drops inside hollow core are reservoir of HIV virus
Psychoactive substance use in group	- Shared needles and unprotected sex as a consequence of drug use.

3. Hormone injection to increase femininity and beauty amongst TG:

Group Injection of hormones, steroids, Botox etc. increases the risk to HIV infection or when the needles and instruments are shared. Apart from the risk of infection there is an increased risk of overdose. Case managers must themselves be knowledgeable of different modes of infection the level of risk involved with different modes.

Infection that can be sexually transmitted

Sexually transmitted infections (STIs) are important factor which case managers should be aware of. Almost all PHIV have co-infection with other STI, usually multiple STI. The risk of HIV infection among people having STIs is 3 to 5 times higher than those who do not have STIs (Wasserheit JN, 1992).

STI mostly are asymptomatic, particularly for the infection in the mouth and anus, therefore case managers should be aware and look for STIs during evaluation. Co-infection is common. For example around 30-40% of people with gonorrhea are infected with chlamydia. Common STIs among MSM/TG includes syphilis, gonorrhea, chlamydial infection, genital warts. When having symptoms, complaints include pus discharge from penis, swelling of genital organ and inguinal areas, pus discharge from anus, ulcers at genitalia and anal area, and warts, for example (Bureau of Sexually Transmitted Infections, DDC, MOPH, 2009).

Hepatitis:

Viral Hepatitis:

1. Hepatitis A virus infection (HAV)—HAV is through fecal oral route
2. unprotected sex in MSM or fecal oral route. HAV can be protected with (protection not treatment) HAV vaccines.
3. Hepatitis B virus infection (HBV)—HBV is amongst the most potent contagious virus known to human kind, 10-11 virus/ ml of blood will infect a person. Once again only protective vaccines exist.
4. Hepatitis C virus (HCV), Hepatitis D virus HDC, and Hepatitis E virus HEV all more or less are similar to HBV in pathophysiology but unfortunately neither prophylactic nor treatment vaccines exists.

The role of case manager

Almost all clients are embarrassed to talk about sexual problems more so about STI, case managers will have to be a real friend and gradually ask about STI in layman term. Counsel the client for proper diagnosis and treatment.

STIs Prevention important points:

- If clients have multiple sexual partners then client should be tested every 3 months.
- STI increases the risk for HIV infection manifold and progression of HIV is rapider.
- Never ever self-treat STI
- Strict adherence to the treatment is absolutely necessary
- Find a way for sexual partners to be treated else the never ending vicious cycle STI reinfection ensues.
- STI can be transmitted from mother to child or can cause congenital abnormalities.
- All PHIV with STI should be tested for STI regularly and if undergoing treatment doctor prescribing ARV should be told.
- Case managers should ensure client abstains from sexual activity till fully cured.

STI prevention and risk lowering

Self-protection from HIV is a universal right and responsibility of every human being so each and every time clients have sexual contact protection with use of condom is necessary, sexual partners must be counseled and if the need arises negotiated with advice about the pro of condom use and cons of not using condom. Case managers should counsel on ways to motivate condom use both by clients and sexual partners, and safe sexual contact e.g. kissing, masturbation, hugging and safe drinking.

Assessment of alcohol and drug abuse

If in the initial assessment case manager found that the client's practice alcohol and drug use. Case manager should then assess the severity or level of dependency if the client is merely using alcohol or if he or she has an alcohol or drug addiction. ICD 10 is used for the diagnosis of drug dependent; it's normally used by skilled health professionals. The case manager can use CAGE-method to conduct an initial screening of client alcohol and drug use, to determine whether referral to doctor for a proper diagnosis and treatment is warranted.

Drug dependency (ICD-10 diagnostic guidelines)

A definite diagnosis of dependence syndrome is usually made only if three or more of the following were present together at some time during the previous year:

- evidence of tolerance, such that increased doses of the psychoactive substance are required to achieve effects originally produced by lower doses;
- physiological withdrawal state when substance use has ceased or has been reduced:
- strong desire or sense of compulsion to take the substance;
- difficulty controlling substance-taking behavior – onset, termination, or levels of use;
- progressive neglect of alternative pleasures or interests because of psychoactive substance use – increased amount of time necessary to obtain or take the substance or to recover from its effects; or
- Persistent substance use despite clear evidence of overtly harmful consequences – depressive mood states consequent to periods of heavy substance use or drug-related impairment of cognitive functioning.

Source: International Classification of Diseases (ICD) website: http://www.who.int/classifications/icd/en/

Substance abuse evaluation

Evaluation of substance abuse should follow ICD 10, but early assessment CAGE can be used.

The CAGE Method

C= cut down, A= annoyed, G= guilty E= eye opener

With just 4 questions, this simple self-test has nonetheless proven accurate in identifying usage patterns that may reflect problems with alcohol. The test specifically focuses on the use of alcohol, while a separate test focuses on non-alcohol drugs: “Drug Abuse Screening Test (DAST)”.

To take the questionnaire, please click the radio button next to the selection which best reflects how each statement applies to you. The questions refer to your feelings and behavior over your whole life. Carefully read each statement and decide whether your answer is yes or no. Please give the best answer or the answer that is right most of the time.

Please note: This test will only be scored correctly if you answer each one of the questions.

1. Have you ever felt you should *cut* down on your drinking?

Yes / No

2. Have people *annoyed* you by criticizing your drinking?

Yes/ No

3. Have you ever felt bad or *guilty* about your drinking?

Yes/ No

4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (*eye*-opener)?

Yes/ No

1-2 Yes= probable

3-4 yes= certain alcoholism problem.

CHAPTER 3

HTC results positive: Case management

STEP2: Care and Support after HTC results

HIV Test Result: Positive

Care and support for People living with HIV (PHIV) begins with psychological support, allaying fears, anxiety and depression and motivating the client to have a CD4 count test and to access to ARV treatment as appropriate. Client reactions vary, but usually follow the common responses described in the following table. An understanding of client defense mechanisms is needed for the case manager in providing appropriate care and support.

Psychological reaction to HIV positive test result

Table: Common defense mechanisms

Defense	Description mechanism
Repression	Exclusion from awareness of memories, emotions and/or impulses that would cause anxiety or distress if allowed entering consciousness
Denial	Similar to repression and occurs when patients behave as though unaware of something that they might be expected to know, e.g. a patient who, despite being told that a close relative has died, continues to behave as though the relative were still alive
Displacement	Transferring of emotion from a situation or object with which it is properly associated to another that gives less distress
Identification	Unconscious process of taking on some of the characteristics or behaviors of another person, often to reduce the pain of separation or loss
Projection	Attribution to another person of thoughts or feelings that are in fact one's own
Regression	Adoption of primitive patterns of behavior, appropriate to an earlier stage of development, it can be seen in ill people who become child-like and highly dependent
Sublimation	Unconscious diversion of unacceptable behaviors into acceptable ones

Important roles of case managers in providing care and support to PHIV

The main roles of the case manager after learning a client has just tested positive for HIV:

1. **Start with psychological support**, with the following objectives.
    a. Allow client to express his/her feelings, letting the client ventilates their pain/suffering.
    b. Reassure the client that he/she is not alone; the case manager cares and is ready to help.
    c. Assess client's emotions to provide relevant support
    d. Assess whether there is risk for self-harm

2. **Answer the client's questions clearly and correct any misunderstandings** on issues related to HIV.
   Client anxieties/fears should be reduced with clear information. The common questions that clients ask are: How long will they live? What is the next step? What are the symptoms that they will have? Thus, the case manager needs to provide them with current information on HIV and the treatment.

3. **Provide information pertaining treatment and the steps in accessing treatment.**
   For Thai population, they should be informed about their rights to treatment provided by the National Health Security Office (NHSO).

4. **Establishes communication channels** (telephone number, Facebook, Line application etc.)
    a. Communication channels should be established, by case manager, right at the first encounter after knowing HIV test result. The counseling channel could be establish during the encounter i.e. case manager record client's telephone number (or add line contact) and then call him/her to simultaneously provide the client with case manager's contact number.
    b. Tell the client that he/she can always call when they feel uncomfortable i.e. worried, depressed
    c. Ask the client to inform you when they change their telephone number

5. **Case manager follow up (within 48 hours)** through phone or other established communication channel.

6. **Get an appointment for CD4 count test.**

Case manager attitudes

- **Case manager need to understand it's hard for the clients to cope with the news that they are now living with HIV and the illness significantly affect the client's life.**
- **Case manager need to understand that the client might be shifting through various emotional reactions to the test result.**

Strategies to support the client after learning of their positive test result

- Express that they understand the client, through verbal and non-verbal communication: i.e. appropriate touch, eye contact, supporting words.

- Reassure the client by letting him/her know that he/she is not alone or the only one who has received a positive result and is living with HIV. The case manager may provide examples of others who have come to terms with the test results.

- Let the client know that you are there ready to support.

- In the beginning, the client may not be ready to express his/her self. The case manager should remain with the client and allow him/her to be silent. Silence is important because it gives the client time to think about what to say, the chance to experience his or her feelings, the ability to proceed at his or her own pace, time to deal with ambivalence about sharing, and freedom to choose whether or not to continue. Then, explore client's feelings using open-ended questions, for example, ***"I am wondering what you are thinking/feeling right now?"*** These questions will help case manager express empathy and to understand the client thinks and feels. Ask the client directly if he/she is thinking of self-harm or harming others.

- Ask the client how he/she will return home and if there is someone who can stay with him/her. Follow-up by calling the client to see if he/she has returned home safely and that he/she is not alone.

- Ask client to make a promise that he/she will not harm his/ her self before you next meeting. Let the client know that he/she can call you to talk if they cannot wait till the next appointment.

Assessment of client's tendency for self-harm and suicidal risk is essential at this stage.

Assessment of risk for self-harm

Client with symptoms of depression are at risk of self-harm. Depression is characterized by the features in the table below.

Table: Character features of depressive illness

Mood	Depressed, miserable or irritable
Speech	Impoverished, slow, monotonous
Energy	Reduced, lethargic, lacking motivation
Ideas	Feelings of futility, guilt, self- reproach, unworthiness, hypochondria, worrying, suicidal thoughts, delusions of guilt, nihilism and persecution
Cognition	Impaired learning, pseudo dementia in elderly patients
Physical	Insomnia (especially early waking), poor appetite and weight loss, constipation, loss of libido, erectile dysfunction, bodily pains
Behavior	Retardation or agitation, poverty of movement and expression

Apart from self-harm, case manager needs to assess whether the client has suicidal tendency.

SUICIDAL RISK ASSESMENT: LOOK FOR THE WARNING SIGNS:

What are warning signs and why are they important?

There are a number of known suicide risk factors. Nevertheless, these risk factors are not necessarily closely related in time to the onset of suicidal behaviors – nor does any risk factor alone increase or decrease risk. Population-based research suggests that the risk for suicide increases with an increase in the number of risk factors present, such that when more risk factors are present at any one time the more likely that they indicate an increased risk for suicidal behaviors at that time.

A recent review of the world's literature has identified a number of warning signs that empirically have been shown to be temporally related to the acute onset of suicidal behaviors (e.g., within hours to a few days). These signs should warn the clinician of ACUTE risk for the expression of suicidal behaviors, especially in those individuals with other risk factors (Rudd, et al., 2006). Three of these warning signs (bolded on the VA SUICIDE RISK ASSESSMENT Pocket Card) carry the highest likelihood of short-term onset of suicidal behaviors and require immediate attention, evaluation, referral, or consideration of hospitalization.

The first three warning signs are:

1. ***Threatening to hurt or kill self***
2. ***Looking for ways to kill self; seeking access to pills, weapons or other means***
3. ***Talking or writing about death, dying or suicide***

The remaining list of warning signs should alert the case manager that a medical service provider will need to conduct a mental health evaluation in the VERY near future and that precautions need to be put into place IMMEDIATELY to ensure the safety, stability and security of the individual.

1. Hopelessness

2. Rage, anger, seeking revenge
3. Acting reckless or engaging in risky activities, seemingly without thinking
4. Feeling trapped – like there's no way out
5. Increasing alcohol or drug abuse
6. Withdrawing from friends, family or society
7. Anxiety, agitation, unable to sleep or sleeping all the time
8. Dramatic changes in mood
9. No reason for living, no sense of purpose in life

Other behaviors that may be associated with increased short-term risk for suicide are when the patient makes arrangements to divest responsibility for dependent others (children, pets, elders), or making other preparations such as updating wills, making financial arrangements for paying bills, saying goodbye to loved ones, etc.

Suicide Risk Assessment Guide

Issue	High risk	Medium risk	Low risk
At risk' Mental State – depressed – psychotic – hopelessness, despair – guilt, shame, anger, agitation – impulsivity	Eg. Severe depression; Command hallucinations or delusions about dying; Preoccupied with hopelessness, despair, feelings of	Eg. Moderate depression; Some sadness; Some symptoms of psychosis; Some feelings of	Eg. Nil or mild depression, sadness; No psychotic symptoms; Feels hopeful about the future; None/mild anger, hostility.
Suicide attempt or suicidal thoughts – intentionality – lethality – access to means	Eg. Continual / specific thoughts; Evidence of clear intention; An attempt with high lethality (ever).	Eg. Frequent thoughts; Multiple attempts of low lethality; Repeated threats.	Eg. Nil or vague thoughts; No recent attempt or 1 recent attempt of low lethality
Substance disorder – current misuse of alcohol and other	Current substance intoxication, abuse or dependence.	Risk of substance intoxication, abuse or dependence.	Nil or infrequent use of substances.
Corroborative History – family, careers – medical records – other service providers/ sources	Eg. Unable to access information, unable to verify information, or there is a conflicting account of events	Eg. Access to some information; Some doubts to plausibility of person's account of events.	Eg. Able to access information / verify information and account of events of person at risk (logic, plausibility).

Strengths and Supports (coping & connectedness) – expressed communication – availability of supports – willingness / capacity of support person/s	Eg. Patient is refusing help; Lack of supportive relationships / hostile relationships; Not available or unwilling / unable to help.	Eg. Patient is ambivalent; Moderate connectedness; few relationships; Available but unwilling / unable to	Eg. Patient is accepting help; Therapeutic alliance forming; Highly connected / good relationships and supports;
Reflective practice – level & quality of engagement – changeability of risk	Low assessment confidence or high changeability or no rapport, poor engagement.		– High assessment confidence / low changeability;
No (foreseeable) risk: following comprehensive suicide risk assessment, there is any evidence of current risk to the person. No thoughts of suicide or history of attempts, has a good social support			

Is this person's risk level changeable? **Highly Changeable** **Yes** **No**

Are there factors that indicate a level of uncertainty in this risk assessment? E.g.: poor engagement, gaps in/or conflicting information.

Low Assessment Confidence **Yes** **No**

Social Care and Support: Care Co-ordination

Access to health care services is a crucial part of the treatment cascade. Case managers play an important role in helping getting the access. Many clients do not know their rights. There are various health care schemes in Thailand: Universal Coverage by National Health Security Office (NHSO), Social Security, by National Social Security Office (NSSO) and civil servant scheme. All Thai people are covered by the universal health care scheme but a legally employed person's health care coverage might fall under either civil servant scheme or social security scheme.

Case manager role as care coordinator in access to health care

Case managers will need to help PHIV clients find out under which medical facilities they are registered under the NHSO universal health care scheme or help them transfer their registration to another facility. There are a large number of PHIV who do not know the hospital they are registered under or the treatments they are entitled to under NHSO. Case managers should ensure clients know their rights and to benefit from them.

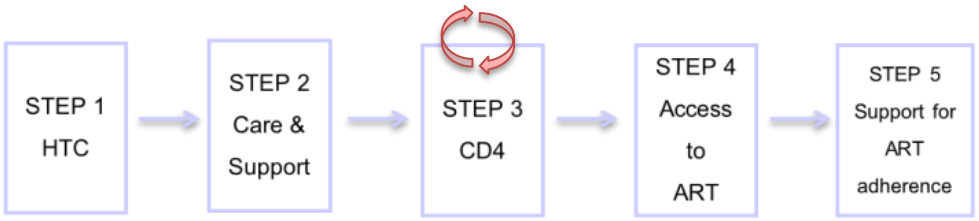
The methods to achieve the above are as following (The POZ Home Center, 201-; Nitisak, 2014)

1) Those clients who have never used NHSO services use the national ID number (13 digits) to check from the NHSO web site. www.nhso.go.th/peoplesearch
2) Those clients whose are registered far way in different province or is inconvenient to use their current hospital will need to get their registration transferred case managers will need to get it done along with the following documents
   i) Copy of rent agreement, client name should be in the agreement else the tenant will have to provide affidavit proving the client residence at the mentioned address.
   ii) Copy of Thai National ID card
   iii) Copy of house registration
   iv) Affidavit from the house owner stating that the rent agreement is true and authentic.
   Case manager along with client then contact any of NHSO office in the District offices (please do check beforehand that the said district office have NHSO desk or not) the transfer is done every 15th and 28th of the month. Then telephone 1330 NHSO help desk to follow up the status of the transfer. Then get the client referred to a secondary or tertiary of specialized medical facilities.
3) Clients who are already registered in Bangkok and if clients are comfortable with the place case managers can get the treatment started. (find out the location from www.nhso.go.th/pp/mcumap.php)

4) In case clients are not comfortable or it is inconvenient then case manager will have to transfer the registration to a convenient (for the client not the case managers) unit as outlined above.
5) Clients who are covered under NSSO health scheme case managers will have to contact zonal NSSO transfer is possible if i) clients changed job, ii) changed his home address.
6) NSSO transfer registration between 1st January and 31st March of the year, midyear transfers are possible only when there is a job change or home address change.
7) Cases where employers select the Hospital for their employees the human resource department (HR) will have to be notified for a transfer of registration.
8) Hotline for NHSO is 1330 and NSSO is 1506.
9) Case manager will have to take clients to the primary health unit; primary care unit will refer to secondary or tertiary care as per the case.

Chapter 4

Care and Support: Getting CD 4 count testing



STEP3: Care and support to get CD4 testing

The third step is another important step, when client agrees for a CD4 count testing, it means that the client has psychologically and emotionally accepted his or her HIV sero-status. Another reason for being an important step is that studies after studies have found out clients usually take the CD 4 count test first time and if the result comes back with a high CD4 count clients become complacent and loses follow up testing resulting in very low CD4 count and in full-blown AIDS stage. To prevent these unfortunate stage case managers must ensure regular follow up testing.

Clients with high CD4 count

Client with high CD4 cell count are generally healthy, thus, become complacent about getting CD4 cell count, on a regular basis. Thus the main role of case manager for this case situation is to provide clients with sufficient information to raise their awareness. At the same time, case managers should check client's understanding about the importance of the test.

Case manager's role

1. Case manager must evaluate the awareness level of clients (from here on clients are friends of case managers) about CD4 count and Viral Load (VL) then coach and counsel to clear up all the myths misunderstandings. What they should do to keep high CD4 level i.e. prevention of additional infection, lead a healthy life style.

Explanation of CD4 Count:

Healthy	500 - 1,660
Borderline Low	350 - 500

Low	200 - 350
Extremely Dangerous	0 - 200

2. Treatments rights of clients must be told(all Thai citizen can have access to CD4 testing when they found a positive result for HIV test)

al CD4 testingThai Nationunder universal coverage (NSHO, 2013)

CD4 (those not under ARV Tx)	Rules
CD4 > 500 cells/mm^3	Once a Year
CD4 350 - 500 cells/mm^3	Twice a Year

3. Case manager must ensure for a follow up CD4 count test every 6 months regardless of clients CD4 count and current health status. Case manager should provide clients with a knowledge that CD4 cell count is like comparable to their health checkup.
    a. Case manager should inform the clients about the benefit of getting CD4 cell count and keeping CD4 high.
    b. The effect of neglecting. What happens if CD4 level falls and provide clients with the knowledge about opportunistic infection (OI). Case managers should aware that the information about OI is given to raise awareness in keeping CD4 level high, not to worrisome.
4. Make a follow up appointment: at 3 or 6 months depending on the CD4 level, in case of high CD4 level the follow up appointment should be at 6 months.
    a. A communication channel between case manager and the client should be agreed and established.
    b. Ask the client to note down and find the way to remind themselves for the follow up visit. The note taken should be general information i.e. 3rd March 2015 time for regular checkup (2/2)
    c. Case manager should note the date to call and ask if the client get CD4 count as planned. The calling date should be one day later than the date the client has planned to get CD4 cell count i.e. 4th March 2015 call Mr. X to check if he gets CD4 cell count.
5. Lifelong plan must be discussed and implemented. The plans must include Health, income, HIV status disclosure, love life and other relationships.
    a. Ask the client: “What is his plan about ……?”

6. Six months after the first test, case manager contacts client and ask him the reason case manager is calling this way try and build up rapport with client and ensure regular checkups.
    a. Ask the client knows the reasons for the call?
    b. Ask about the plan on CD4 cell count
    c. Ask if the client needs the case manager help in accompanying? Make an appointment with the client if a company is needed. If not case manager should agree with the client on when the case manager should call to follow up the CD4 test result.

7. Recommend them to use applications that help them remind about their check up and reliable websites for them to learn more.

Clients with CD4 lower than 500

Clients with low CD4 count often have negative attitude about getting treatment. I this is the case, case managers need to help the client motivated to get the treatment. The motivating process, in fact starts from checking client's awareness of the problem, by checking client's understanding about the need to get ARV, in which stage they are in the model of change. Case manager should ask if the client experienced OI, if he has knowledge about OI and preventive measures.

Although having knowledge, many clients remain ambiguous about getting ARV treatment. Case manager should help the client using pros and cons technique. The following table explained strategy to motivate clients and help them move forward to get ARV treatment.

The chart below illustrates the strategy in to motivate PHIV with low CD4 cell count to consider starting ART

STAGES OF CHANGE	STAGE SPECIFIC BEHAVIOR CHANGE STRATEGIES		
PRE-CONTEMPLATIVE STAGE The client does not see the importance of starting ARV. *"It is not yet time for me to*	**Story-telling:** Tell the client a "Success story" that highlights similar obstacles to change and potential solutions	**Information giving:** Specific to the client's situation √ *What do you know about …?* √ *What would you like to know*	**Discuss impact of behavior:** How behavior is negatively impacting opportunities for better health. √ *How do you think taking*

think about taking ARV."	√ *Another one of my clients ….*	*more about.?*	*medication might help you stay healthy longer?*
CONTEMPLATIVE STAGE The client sees the benefits of starting ARV but is still hesitant to change *"Yes, I worry that I have not yet started medication but …"*	**Explore ambivalence** Help the client to see why he or she is on the fence. √ *What are some of your concerns about taking ARV?*	**Discuss pros & cons:** Explore the client's costs and benefits of change: √ *What for you are some good and bad things about starting ARV?* **Increase self-efficacy:** √ *You mentioned that you exercise to stay fit and healthy. How can ARV help you continue doing this?*	**Discuss behavior in relation to self-image:** √ *You work hard to help your family / get an education but how long can you do these things if you don't start medication?*
DETERMINATION / PREPARATION STAGE The client is ready to start ARV medication. *"I want to start taking anti-retroviral medication"*	**Getting started / Planning:** Help the client to plan to accomplish the behavior change √ *Help the client make a plan to fit his/her treatment regimen into a daily routine.* √ *Role-play giving reasons for taking medication in different stuations.*	**Build self-efficacy, confidence, practice skills and establish a first step:** √ *Practice taking medication with mock pills or candy* √ *Understands non-adherence leads to resistance and understands that resistance can be paseed to others through unprotected intercourse of sharing injecting equipment*	**Support and referral:** √ *Has emotional and practical life supports, e.g. has family members, friends, community volunteers or members of PHIV clubs to support him or her in taking medication*
ACTION STAGE Client taking ARV *"I have started taking ARV."*	**Continued support:** Partner, friends, family member √ *Remind client of when to take his or her medication.* *Counselor* √ *Assist client in reducing any unforeseen barriers.*	**Find substitutes:** If the client encounters side effects √ *Knows how to manage common side-effects of the medication, e.g. nausea, vomiting, diarrhea, etc.*	**Follow-up** Follow-up on the client's experiences √ *Adherence assessment on a basic level on all visits* √ *Refer client for clinical monitoring of side effects*
MAINTENANCE STAGE Client anticipates triggers for relapse and coping strategies *"I can anticipate what may happen and prepare myself accordingly"*	**Recognizing relapse as part of the change process** Assist client in identifying possible "triggers," which may lead to a laps in taking ARV and how he / she may cope with these. **Identifying rewards:** For maintaining change	**Find substitutes:** If a dose is missed √ *If a dose is missed should not be taken more than 30 minutes after the designated time.* √ *If you forget to take your medicine take it immeditately when you remember. But if your next dose if less than two hours from the time you remember don't take the missed dose. Take*	**Identify supports:** Help client identify peer support √ *Who has experience in taking medication and can help you keep to your timetable?* **Become a role model:** Help the client become a role model of change for peers

		the new dose at the designated time.[5]	
RELAPSE STAGE The client may have had a time when they didn't take his/her medication *"I forgot to take my medicine this time but …"*	**Recognizing what leads to relapse:** Help client identify and understand circumstances that led to the missed dose	**Highlight triggers/barriers to lapse:** Review plan and encourage confidence that they are able to continue taking medication as prescribed	**Review and modify plan:** Identify what has worked and what has not √ A missed dose doesn't mean failure it means that we have to review
TERMINATION	**Client is 100% confident in all trigger situations** **Congratulate the client and again remind him or her that you are available for continued follow-up**		

Role of case manager in step 3, getting CD4 result

The Case managers' role is to be the client's company in helping them plan their life and eventually stand on their own. **The process of care and support is as following:**

1. Assess client's knowledge, understanding, concerns about ARV treatment, using stage of changes model to assess their readiness to take ARV and motivational interviewing to make them move forward.
2. Give additional information about ARV treatment
   a. Provide information on the benefits of CD4 and viral load (VL) tests and the meaning of the respective test results
   b. Ask them to assess themselves and elicit questions to help them think and discuss the following issues.
      i. Benefit of treatment with ARV
      ii. What would happen if they do not take ARV
      iii. What happens after getting ARV
      iv. Why ARV needs to be taken regularly and continuously
      v. Self-care when the CD4 count is low
      vi. OI that comes with low CD4 count
3. Give clients time to think and assess their readiness to take ARV

[b] *ARV adherence, Bureau of AIDS, TB and STIs, DDC,MOPH, 2004.*

4. Inform clients about their right to get the access to ARV treatment and the services that is covered by National Health Security scheme as mentioned earlier.
5. Make sure clients get an appointment for further follow up client log the appointments themselves. Case managers then contact through phone and ask about the appointment. Advise about modern communication such as Facebook/ line application etc.

At this point clients might either be ready decide to get ARV treatment, or remained hesitant. Therefore, case and support can fall into two care and support lines of management.

5.1 Care and support for clients who are not ready for ARV treatment

5.1.1 Case managers provide client with information about self-care

5.1.2 Explain the clients the effects when CD4 count falls

5.1.3 Continuous follow up and tracking CD4 level, keep reminding the client to check their CD4 level

i. Ask the client to repeat CD4 count after 3 or 6 months
ii. Agree and establish a communication channel
iii. Ask the client to note down and find the way to remind themselves for the follow up visit. The note taken should be general information i.e. 3rd March 2015: time for regular checkup (2/2)
iv. Case manager should note the date to call and ask if the client get CD4 count as planned. The calling date should be one day later than the date the client has planned to get CD4 cell count i.e. 4th March 2015 call Mr. X to check if he gets CD4 cell count.

5.1.4 Help the client in reviewing what has happen and what their life plan is in short and long terms about following issues:

i. Health care plan
ii. Employment and income
iii. Disclosure of their HIV status
iv. Love and relationship

5.1.5 Make sure and find the way to be in touch with the clients

5.1.6 Regularly follow-up the client and remind them to get CD4 count

i. Ask if the know the reason for the follow up call, and explain that your call is to make sure that their reminding system to get CD4 count works, to help improve self-care.
ii. Ask how about the plan to get CD4 count

iii. Ask if they need company to the hospital. If they need a company make an appointment with the client on the place and time to meet. If the clients do not need a company, tell them that you are willing to follow up the results after receiving CD4 count.

5.1.7 Introduce the client to telephone and computer applications that can help remind them of appointments and websites with up-to-date information on treatment services

5.2 Care and support for clients who are ready for ARV treatment services

5.2.1 Making an appointment on date that the client would make to access ARV treatment

5.2.2 Case manager should help in the training clients to correctly take ARV (punctuality) in which may start by using placebo or candies with an aim to

- Take ARV punctually and continuously.
- Identify appropriate time be able to take ARV at a regular interval

5.2.3 Recommend application that they can use to remind them in taking medicine and reliable online database.

5.2.4 Help the client in reviewing what has happen and what their life plan is in short and long terms about following issues:

i. Health care plan
ii. Employment and income
iii. Disclosure of their HIV status
iv. Love and relationship

Essential Knowledge for case managers

CD4 cell count:

The terms “CD4 cell” and “T-cell” both refer to the same type of cell—a *CD4 T lymphocyte*—and are used interchangeably. CD4 cells or T-cells are a type of white blood cells that play a major role in protecting from infection. CD4 cells send signal to activate immune response when intruders are detected. When HIV virus infected CD4 cell, it destroy the cell and the immune system. Hence, CD4 cell count decrease, as well as immune response to infection.

CD4 indicates the immunity response; if CD4 level is low, there will be deficiency in the immune response to infection. People living with HIV should check CD4 count every 6 months, and if the CD4 cell count is lower than 200-350 cell/mm^3, they should have more frequent CD4 cell count, every 3 months. “PHIV should take care themselves leading a healthy lifestyle so they can keep CD4 cell count high to prevent opportunistic infection”. The CD4 count in a normal people is 500-1800 cell/mm.^{3}

For this reason, the level of CD4 cell count is usually used as an indicator to help in the decision on whether the client should take ARV.

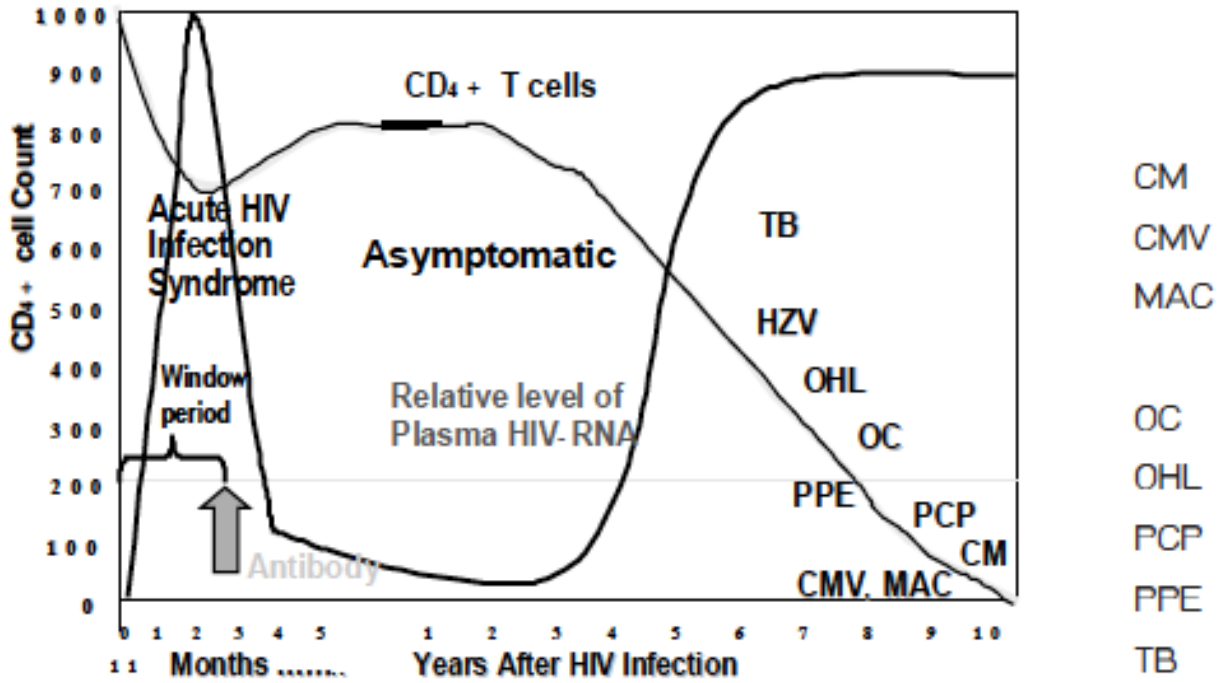


Figure: Natural course of HIV and common Opportunistic Infection (BATS, 2004)

Early treatment

For clients with normal CD4 cell count, i.e. higher than 500 cell/mm^3, there is sufficient evidence of the public health benefits of starting ARV treatment for prevention of HIV among sero-discordant couples, or to prevent transmission from mother to child. Hence, ARV is now accessible HIV treatment at any CD4 level for Thai nationals and covered by universal health care coverage (NHSO, 2014). However, there is still insufficient clinical evidence on health benefits of early treatment when CD4 500 cell/mm^{3}under other circumstances.

Viral Load (VL)

Viral load is the term used to describe the amount of HIV in a body fluid. Viral load tests measure the amount of HIV in a small sample of blood. The result of a viral load test is described as the number of 'copies' of HIV's genetic material (RNA) per milliliter (copies/ml).

There are a number of different viral load tests in use. All the tests are equally reliable at determining if a viral load is high, medium or low. However, each test has a limit below which it cannot reliably detect HIV. This is referred to as viral load being 'undetectable'. Undetectable viral load is usually defined as below 50 copies/ml, the lowest detectable level for tests most commonly used in routine viral load monitoring. This does not mean that there is no HIV in the sample, just that the number of copies is somewhere between 0 and 50. However, there are now some ultra-sensitive tests that can measure below 20 copies/ml.

Changes in the viral load over time, along with other indications, particularly the CD4 count and the presence of HIV-related symptoms, can help in the decision on when to start HIV treatment, and when to change ARV regimen.

Among people with the same CD4 count, those with higher viral loads tend to have more rapid disease progression than those with lower viral loads.

Opportunistic Infection (OI)

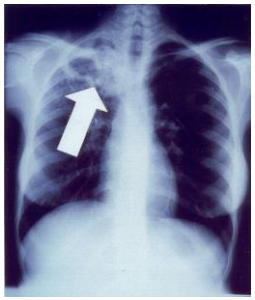
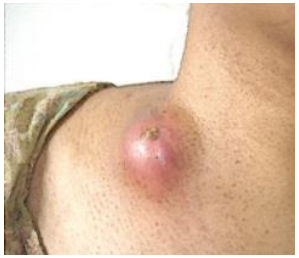
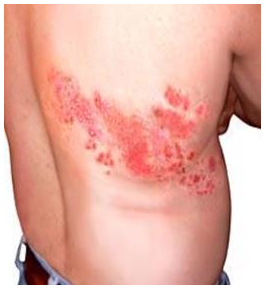
People with normal immune systems can be exposed to certain viruses, bacteria, or parasites and have no reaction to them—but PHIV can face serious health threats from what are known as “opportunistic” infections (OIs).

These infections are called “opportunistic” because they take advantage of your weakened immune system, and they can cause devastating illnesses. OIs are signs of a declining immune system. Most life-threatening OIs occur when CD4 count is below 200 cells/mm^3. The detail of Opportunistic Infection is provided in the following tables.

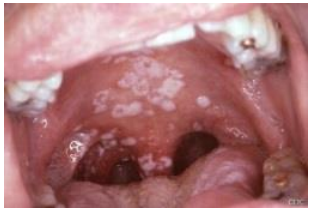
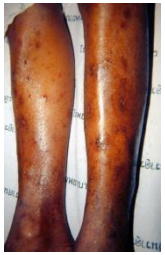
Table: CD4 count and Opportunistic Infection and Prophylaxis

CD4 count	Disease	Prophylaxis for OI
normal count	TB and Lymph node adenitis	
<350	Herpes zooster	
<200	PCP Fungal meningitis PPE Dementia	Cotrimoxazole single-strength tablet 2 tablets once a day.
<100	Cryptococci meningitis Cerebral abscess due to Toxoplasma	Fluconazole 400mg once a week usually every Wednesday.
<50	MAC	Clarithromycin or Azithromycin

Opportunistic infections, clinical presentation, treatment and adverse effect from treatment

CD4 count	Disease	Sign & symptoms	Treatment	Adverse effect of Rx.
Normal count	**Tuberculosis: TB** 	Low grade fever 3-4 days a week, weight loss, yellowish sputum cough in the morning LN growth	Isoniazid,INH,H / Rifampicin,R Pyrazinamide,Z / Ethambutol Ethanbutol DOTS for PHIV are 12 months in place of 6 months.	Peripheral Neuritis Skin rashes, yellowing of tears and skin and urine deafness with steptromycin use.
	Lymph node adenitis 	Growth of lymphnodes with fever and pain or asymptomatic	ARV reuduces the incidence rate but if the growth becomes chronic despite Tx. then excisional diagnostic has to be performed.	
<350	**Herpes Zooster** 	Begins with muscular pain for 2-3 days and then reddish base vesicles with discharge high itching	Accyclovir 800 mg 5 times a day have been known to reduce the symptoms span.	

Opportunistic infections, clinical presentation, treatment and side effects from treatment (continued)

CD4 count	Disease	Sign & symptoms	Treatment	Adverse effect of Rx.
<200	**PCP (pulmonary)**	High fever, productive cough, breathlessness, Apnoea and Respiratory failure.	Cotrimoxazole 500 3 times a day till cure is achieveved then once a day till CD4 reaches >200.	fever nausea vommiting skin rashes ADE (acute drug erruption)
	Oral Candidiosis 	yellowish to white painful patches in oral cavity causing dysphagia.	Candinas troche -tab 5 times a day for 7 1 .days 14	Hepatitis, Migiranic headache nausea vomitting abdominal pain
	Superficial PCP 	from painfull itchy swelling to rashes speading all over the lower limbs.	medium potency steroid lotion or cream till symptoms resolve. Oral antihistamines for itching	First and second generation antihistamines causes drowsiness.
	Dementia	Neuritis and neuralgia with decreasing both long term and short term memory	ARV reduces the progression of Dementia.	

Opportunistic infections, clinical presentation, treatment and side effects from treatment (continued)

CD4 count	Disease	Sign & symptoms	Treatment	Adverse effect of Rx.
<100	**Cryptococcal meningitis**	High fever, poor orientation to time, place and person, drowsiness, flaccid muscles, neck stiffness	AmphotericinB IV for 2 weeks Fluconazole 400mg for 3 months then 200mg till CD4 count 200	AmphotericinB is injurius to Liver and Kidney.
	Toxoplasma meningitis	High fever, poor orientation to time, place and person, drowsiness, flaccid muscles, neck stiffness		
	Cytpmegalo virus infection (CMV) particularly when eyes are affected.	Blurred vision, dipplopia, blindness.	Gancyclovir	Drug induced Haemolytiv anemia
<50	**PseduTB**	High Fever, Myalgia, Jaundice, Anemia	Azithromycin, Clarithomycin Ethambutol	

Self-care for common Opportunistic Infection (BATS, 2012)

Oral Candidiasis:

1. Clotrimazole oral paste 3-5 times a day.
2. Avoid wounds during teeth brushing or chewing
3. Oral hygiene
4. Try for soft non-spicy food preferably room temperature.
5. Plenty of fluid intake rule of thumb till colorless urine.

PPE Rashes:

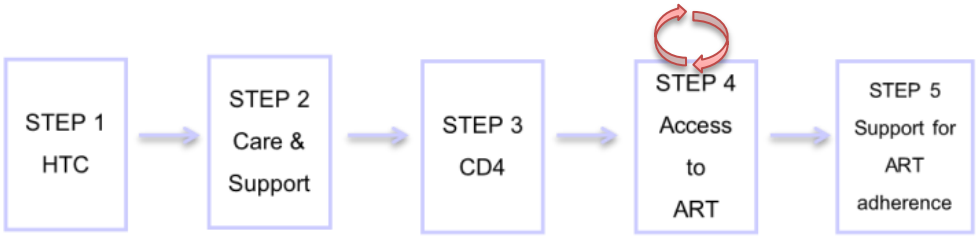
1. Avoid scratching the itch.
2. Trim the nails to shortest possible length
3. Topmost personal hygiene
4. Loose fitting clothes
5. Anti-Histaminic lotion for itch
6. CPM or Atarax oral Rx for stubborn itching.

Pulmonary PCP:

1. Drink as much fluid as possible best is sipping ORS once again drink till colorless urine.
2. If on bed rest keep turning and changing position.
3. To prevent swallowing the sputum try to be upright or use high pillow during coughing episode.
4. Plenty of fluid and rest.

Chapter 5

Care and Support: Access to ARV treatment:



STEP4: Access to ART

1. Case manager and client discuss and solve the problems regarding adherence to ARV treatment.
    a. Assess if the client can regularly take ARV at the same appointed time(s).
    b. What obstacles do they have in taking ARV?
    c. Does the ARV schedule need to be adapted to his/her lifestyle?

2. Case manager sets a schedule for taking ARV and other medicines and coaches clients about timing and dosing.
    a. Helps in arranging the re-packaging of the ARV to help the client be organized
    b. Helps them learn the name of each ARV medication they are taking and the prescribed regimen.

3. Ensure that clients remember the names of their prescribed medications so that they can get it from other places in an emergency.
    a. Highlight why ARV need to be taken on time

4. Clients should be informed of possible adverse effects from taking ARV and that they should contact the case manager if they experience any of these.
    a. Provide information on the side effect specific to the ARV they are taking

b. Tell them about Immune Reconstitution Inflammatory Syndrome (IRIS), and ask them to observe if there are any symptoms that might happen due to IRIS.

5. Strict adherence should be ensured, clients should contact case managers if they miss a dose before taking the next dose.
6. Plan for both the long- and short-term including the following issues:
    a. Health care
    b. Employment and income
    c. Disclosure
    d. Love and relationships

7. Follow-up the CD4 count and Viral Load (VL) count after ARV.
   The NSHO universal health care scheme covers the costs of the CD4 and Viral Load tests according to the following table.

Guidance on CD4 and Viral Load (NHSO, 2013)	
CD4 test (on ARV)	Treatment
CD4 > 350 cells/mm^3 & VL < 50 copies/ml	once a year testing
CD4 < 350 cells/mm^3 & VL > 50 copies/ml	Twice a year
VL (initiating ARV)	Treatment
From start of ARV to VL < 50 copies/ml	twice a year
VL < 50 copies/ml*	Once a year.

*currently VL can be recorded at 20 – 40 virus copies/ml depending on the labs.

8. Case managers should make regular appointments with clients to follow-up problems/obstacles in taking ARV as prescribed.

a. Case manager should schedule frequent follow-up appointments with clients in the initial phase of starting ARV, to check for problems/obstacles in taking ARV, including any side effects.
b. Initially, doctors will prescribe ARV for 14 days, and will then follow-up to evaluate any adverse effects. Follow-up appointments with the doctor will then be scheduled once a month or once every two months.
c. Case managers should manage client-ARV follow-up according to the following table

Table: Case manager follow-up schedule after client starts ARV

Appointment time	Guidance on for the follow up
After receiving ARV	
First day	Talk to the client through phone and ask about the problems if any
First week	Contact client(s) through Line- or other social applications
Second week	Phone and alert the client(s) about their follow-up doctors appointment.

Essential Knowledge for Case Managers

ARV:

Treatment of HIV involves taking a combination of anti-HIV (antiretroviral) drugs. The treatment has powerful effect and stop virus from making copies of itself. Anti-Retroviral (ARV) Therapy in the current form still cannot completely cure HIV but ARV therapy can reduce the VL to less than 20 viral copies/ml leading to near normal life span.

World Health Organization (WHO) latest guideline advises for ARV therapy whenever CD4 count gets lower than 500. However, Thai National Guideline for HIV 2014 suggests that PHIV could have access to HIV at any CD4 and PHIV with CD4 more than 500 patients' readiness and willingness to take ART should be assessed.

PRINCIPLES OF THERAPY

Treatment of HIV infection does not lead to eradication or cure of HIV. Treatment decisions must take into account the fact that one is dealing with a chronic infection. While early therapy is generally the rule in infectious diseases, immediate treatment of every HIV-infected individual upon diagnosis may not be prudent, and therapeutic decisions must take into account the balance between risks and benefits.

Patients initiating antiretroviral therapy must be willing to commit to life-long treatment and understand the importance of adherence to their prescribed regimen. The importance of adherence is illustrated by the observation that treatment interruption is associated with rapid increases in HIV RNA levels, rapid declines in CD4 cell counts, and an increased risk of clinical progression.

While it seems reasonable to assume that the complications associated with ARV could be minimized by regimens designed to minimize exposure to the drugs in question, all efforts to do so have paradoxically been associated with an increase in serious adverse events in the patients randomized to intermittent therapy, suggesting that some "non-AIDS- associated" serious adverse events such as heart attack and stroke may be linked to HIV replication. Thus, unless contraindicated for reasons of toxicity, patients started on ART should remain on ART.

ANTIRETROVIRAL TREATMENT

Combination antiretroviral therapy (cART), also referred to as highly active antiretroviral therapy (HAART), is the cornerstone of management of patients with HIV infection. Suppression of HIV replication is an important component in prolonging life as well as in improving the quality of life in patients with HIV infection. Adequate suppression requires strict adherence to prescribed regimens of antiretroviral drugs. This has been facilitated by the formulations of antiretrovirals and the development of once-daily regimens.

Unfortunately, many of the most important questions related to the treatment of HIV disease currently lack definitive answers. Among them are the questions of when therapy should be started, what the best initial regimen is, when a given regimen should be changed, and what it should be changed to when a change is made. Notwithstanding these uncertainties, the physician and patient must come to a mutually agreeable plan based on the best available data

Currently available drugs for the treatment of HIV infection fall into four categories:

1. those that inhibit the viral reverse transcriptase enzyme (nucleoside and nucleotide reverse transcriptase inhibitors; non-nucleoside reverse transcriptase inhibitors, NRTI, NNRTI)
2. those that inhibit the viral protease enzyme (protease inhibitors),
3. those that inhibit the viral integrase enzyme (integrase inhibitors),
4. those that interfere with viral entry (fusion inhibitors; CCR5 antagonists)

NRTI:

1. Zidovudine (AZT)
2. Lamivudine (3TC)
3. Stavudine (d4T)
4. Didanosine (ddI)
5. Abacavir (ABC)

NNRTI:

1. Efavarence (EFV)
2. NEVARApine (NVP)
3. Etravirin(ETR)

Protease Inhibitors:

1. Lopinavir

2. Aztrazavir
3. Indinavir
4. Saquinavir
5. Darunavir

Integrase Inhibitors:

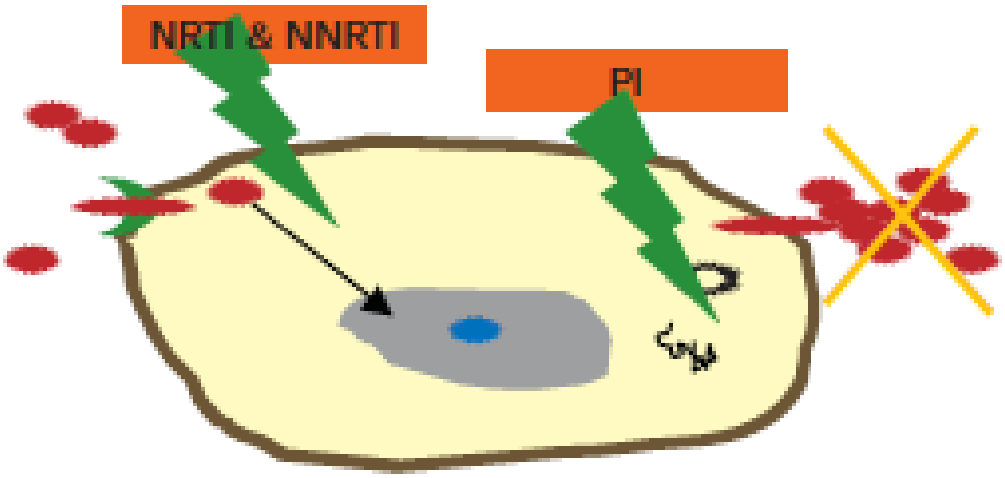
1. Raltegravir (RAL)

Fusion Inhibitor:

2. Malaviloc (MVL)
3. T20.

Currently at least 3 different medicines are combined in a therapy.

AZT/3TC/NVP (GPO+VIRZ250), d4T/3TC/NVP (GPOVIR+S30), AZT/3TC/EFV, TDF/3TC/EFV, TDF/3TC/NVP, AZT/3TC/LPV/r, TDF/3TC/LPV/r.



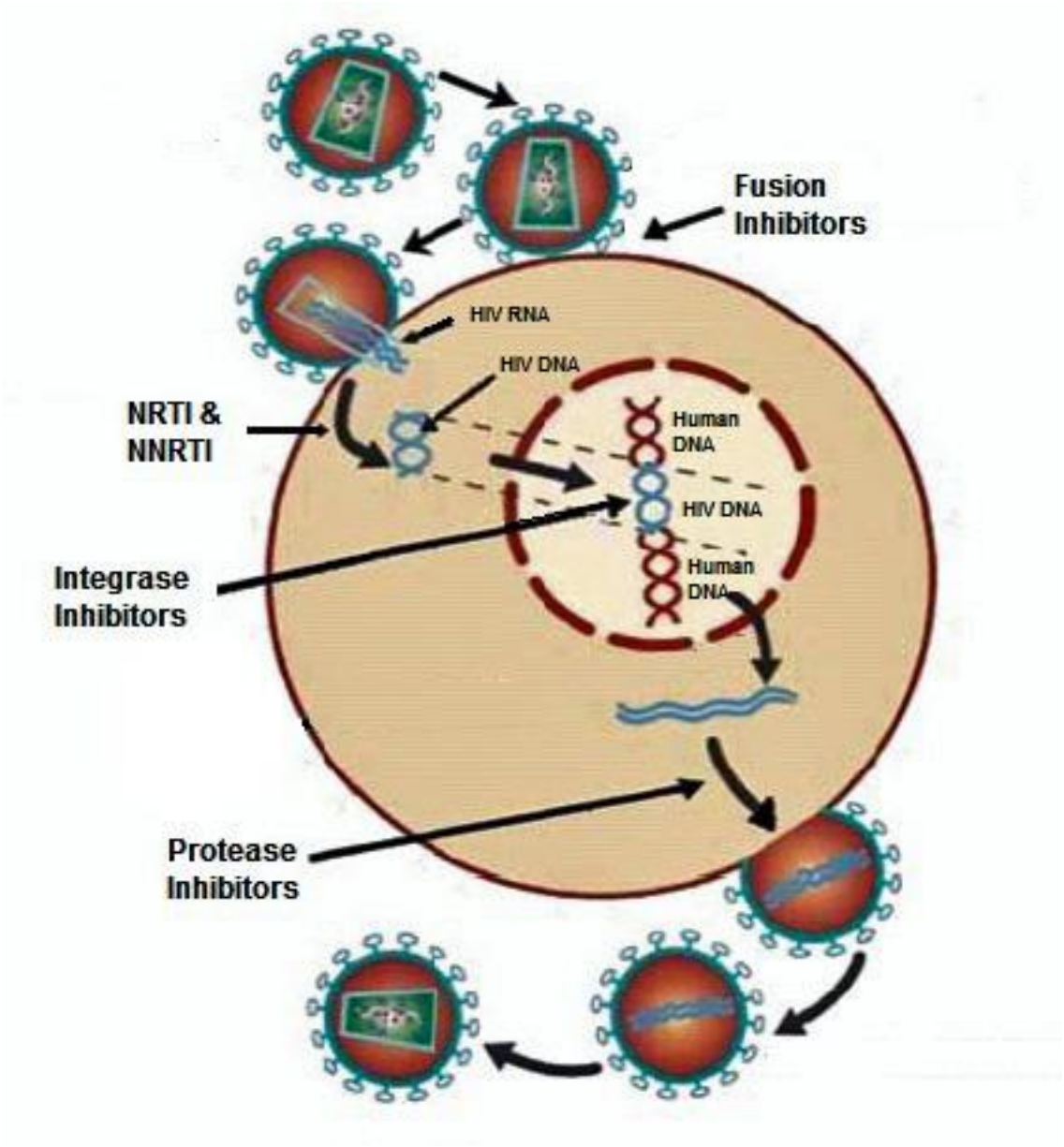


Diagram: mechanism of antiretroviral drugs

IRIS:

Some people who start antiretroviral therapy (ART) get health problems even though their HIV comes under control. An infection that they previously had might return. In other cases, they develop a new disease. This is linked to improvements in the patients' immune systems. The problems usually occur in the first two months after starting HIV therapy. This condition is sometimes called Immune Reconstitution Inflammatory Syndrome or IRIS. It may occur in about 20% of people starting ART.

IRIS has been linked with the several types of infections or inflammation including:

1. Cytomegalovirus
2. Cognitive (memory and thinking) problems
3. Cryptococcal Meningitis
4. Hepatitis B and C
5. Herpes Zoster (Shingles) and Herpes Simplex
6. Molluscum
7. Mycobacterium Avium Complex (MAC
8. Swollen lymph nodes

No single treatment option exists and depends on the underlying infectious agent and its clinical presentation. Prospective cohort studies addressing the optimal screening and treatment of opportunistic infections in patients eligible for ART are currently being conducted. These studies will provide evidence for the development of treatment guidelines in order to reduce the burden of IRIS.

HOW IS THE SYNDROME TREATED?

There is no specific treatment for immune restoration syndrome. Continued HIV treatment strengthens the immune system. This normally takes care of any infections that emerge.

However, in some cases, doctors slowed down the recovery of the immune system. By gradually increasing its strength, they avoided some of the immune restoration responses.

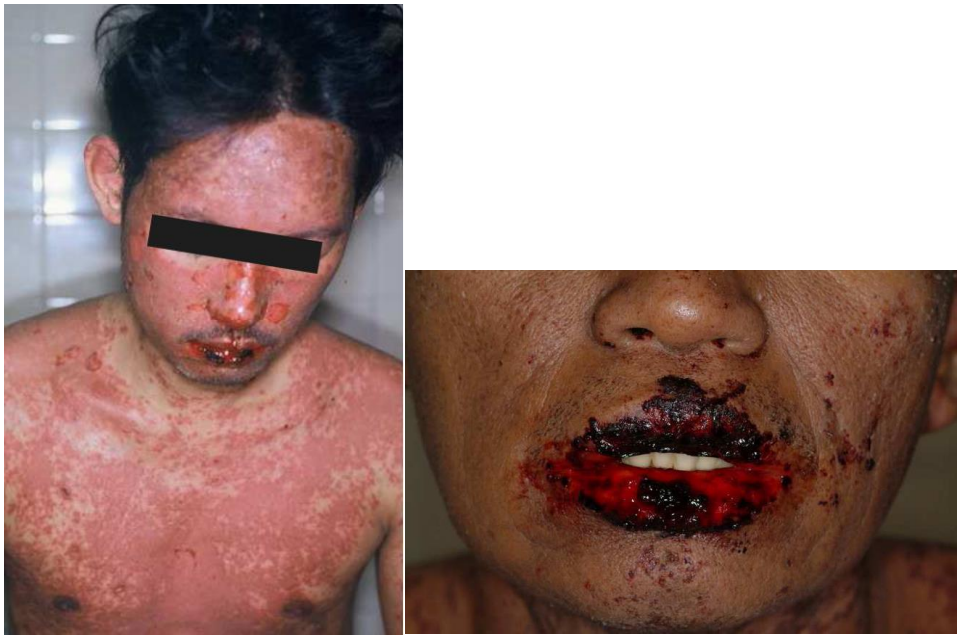
Adverse effect and allergic reaction to ARV therapy

Unwarranted drug actions and or allergic reaction to ARV both can occur during ARV therapy (BATS, 2011)

Allergic reaction:

Allergic reaction can broadly be of two types severe (life threatening) and not so severe. Severe reactions includes dyspnea due to pulmonary edema, oral cavity and eye swelling (mucosal edema) skin peeling off, high fever, skin rashes (some part or whole body) this needs treatment in a hospital, less severe includes itching without visible rashes.

Nevirapine has the highest rate of allergic reaction amongst current ARV medicines; prescribing physician will prescribe half the normal dose for first two weeks then increase to normal dose.



Steven Johnson Syndrome (SJS)

Adverse effects:

Adverse effects are the unwanted or unwarranted therapeutic effects of drugs, such as gastric irritation and nausea vomiting by medications. Adverse effect can be divided into

- Less severe effects which can be self- treated or tolerated by clients, usually the effects last around two months and gradually resolves such as drowsiness abdominal discomfort, diarrhea, Anorexia (appetite loss) nightmares, increased anxiousness and irritability.

- Sever effects which need prompt treatment such as Hepatitis, Peripheral neuropathy, Thrombocytosis or thrombocytopenia; these are common in clients with low CD4 counts.
- Long term adverse effects (after 3-4 years) includes lipodystrophy, Diabetes/ insulin resistance and Lipid abnormalities.

Lactic acidosis:

Increase in Lactic acid level is known as lacticacidosis most common in NRTIs and AZT, the symptoms includes Nausea and vomiting, abdominal pain, tiredness, shortness of breath, abnormal heart beat, weight loss. Possibly may require hospitalization, swathing the drugs is the best treatment.

Lipodystrophy (redistribution of body fat):

Distribution of body fat is often in ways that can be disfiguring and stigmatizing. Three main patterns are seen:

1. Losing fat on the face, arms, legs and buttocks, resulting in sunken cheeks, prominent veins on the limbs, and shrunken buttocks.
2. Gaining fat deep within the abdomen, between the shoulder blades, or on the breasts.
3. A mixture of fat gain and fat loss.

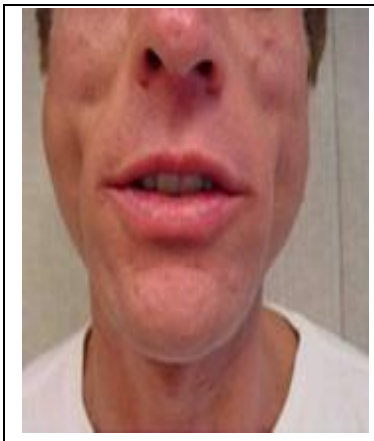
Although lipodystrophy sometimes affects people with HIV who have not taken any antiretroviral drugs, it occurs more often among those receiving treatment. The condition is among the most common long-term side effects of combinations of drugs from the NRTI and protease inhibitor classes. It is particularly associated with stavudine, and to a lesser extent zidovudine. The precise causes of lipodystrophy remain unknown.

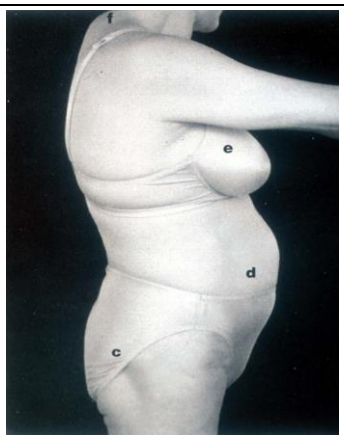
Treatments for lipodystrophy are sadly limited. Changing diet seems to make no significant difference, though resistance exercise (such as weight lifting) may improve the appearance of limbs by building muscle to compensate for lost fat. Any form of exercise will burn fat, which may make some parts of the body look better and others worse, depending on how fat has been redistributed. Aerobic exercise (such as running or swimming) tends to have more effect on the fat just below the skin than on the deep fat gained through lipodystrophy.

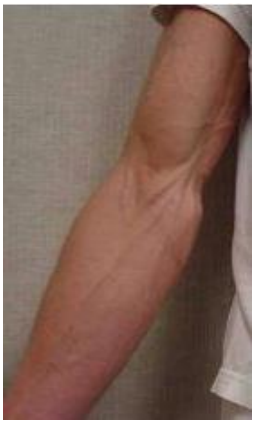
Doctors have tried using various medications, including human growth hormone, to treat lipodystrophy, but few have proved effective, and most have significant side effects. For people who have lost fat from the face, one option is injections of polylactic acid. This

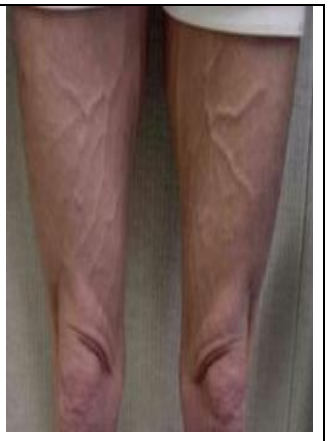
chemical (also known as New Fill or Sculptra) improves facial appearance by thickening the skin.

Switching antiretroviral treatment should stop the symptoms getting worse, but is unlikely to lead to much improvement once the condition has advanced.









Examples of lipodystrophy

Figure: Nail discoloration due to AZT

Common Adverse effect:

Most common adverse effects are Nausea vomiting headache
NRTI: 1. AZT: Anemia, nail discoloration 2. D4T: peripheral neuritis, lipodystrophy 3. 3TC: adverse effects are not common 4. ddL: Diarrhea, peripheral neuritis, hepatitis. 5. Abacavir: acute drug eruption rashes.
NNRTI: 1. NVP: Hepatitis, rashes 2. EFV: Nightmares, psychological problems
PI: 1. IDV : type II DM renal calculi 2. SQV: rashes (safest among the group) 3. RTV Oral paresthesia 4. NFV: Diarrhea, type II DM

How should clients take care of themselves after taking ARV?

- Continuous follow up is needed
- Should strictly follow the recommendation and doctor's prescription
- The medication should be taken regularly and punctually
- Avoid opportunistic infection
- Avoiding additional HIV infection

Recommendation when taking ARV

1. **ARV drugs** can be taken regardless of meal, but it's important that the drugs **need to be taken punctually**, **at regular intervals.** Drugs that are taken twice a day need to be taken exactly at every 12 hours. Each client should set the time to take medicine by him/herself and choose the time that is suitable for his/her lifestyle. The general recommendation is as follows.
   a. The time scheduled for ARV should match with their life style(when they are awaken)
   b. The time scheduled for ARV should be convenient for them to take ARV and be able to remind themselves.
   c. The time scheduled for ARV should not be at times when there are many people surrounding the clients. Some medicine for example, ddI appropriate time for medication also need to consider that it should be taken when there is less acid in the stomach i.e. with empty stomach (before meals or two hours after meals)
2. Before starting ARV, clients should start by learning to adjust the schedule to be able to take the pills regularly, by starting with placebo tablets.
3. If they miss a dose, they can take the missed dose soon as they remember, and then take the next dose as scheduled.
   a. Management with missing dose
   b. In case the client remember the miss doses when the next dose is scheduled to be taken in less than 2 hours. The client can take the miss dose soon as they remember and then skip the next dose
   c. In case that the next dose is scheduled in less 2 hours away from the time when

client remember the miss does. Take the ARV (missing dose) as soon as they remember and then skip the dose that need to be taken in the next 2 hours. After that, take the medicine in the following g dose.

- Except for EFV and for a once a day regimen, the client should skip the missed dose and then take the following dose

4. When client's life schedule changed they can change ARV schedule accordingly. There is no need to slightly adjust, but can be completely different from the initial schedule to match better with the change in the lifestyle. However, the change in ARV schedule should not be often.
5. ARV should be well kept: away from heat, light and humidity, although some medicine might have specific recommendation.
    a. Places that are considered as not suitable are in the car, under the seats in the car, in a cupboard that expose to sun light, under the laundry machine
    b. If the tablet is halved it should not be long in advance before taking
    c. Some ARV drugs need to be kept in the refrigerator

(BATS, 2013)

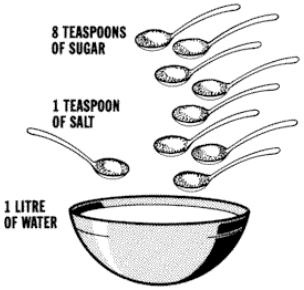
Practical point for the improvement of drug adherence

Preparation before starting ARV

- One method that can be used is experimenting with placebo or vitamins before starting ARV, for two weeks, can help client find out the best schedule to take ARV that match their lifestyle best.
- Motivate clients to have positive attitude towards ARV pills. For example, compare ARV to taking vitamins, which help the client have better health. ARV will help make the client's immunity strong and keep them looking good. To achieve this, they will need to take the ARV pills regularly and continuously.
- Set up a system of reminders:
    - Using an alarm from cellphone, clock etc.
    - Make the time scheduled for ARV pills relevant to the client's life-style
    - Take ARV at a regular interval for example: every 12 hours or every 24 hours. Some people might use daily events to remind them to take ARV, such as the playing of the national anthem in the morning or evening.

ARV Adverse effects		
Headache	Home self-care	See a doctor when
	▪ Massage temporal area ▪ Lay down and rest in a cool dark room ▪ Cold mopping of eyes ▪ Avoid caffeine ▪ Take paracetamol 500mg 1-2 tablets every 4-6 hours (do not exceed 8 tabs)	▪ Blurred vision ▪ Frequent episode unresolved by pain killers ▪ Nausea and or vomiting
Dry Mouth	Home self-care	See a doctor when
	▪ Tepid water gargling ▪ Drink clean water in sufficient quantity (till colorless urine) ▪ Avoid sweet and salty snacks ▪ Avoid caffeine	▪ Unresolved dry mouth ▪ Swallowing difficulties
Pain, tingling and paresthesia of hand and foot	Home self-care	See a doctor when
	▪ Avoid tight fitting foot wear ▪ Warm soaking of foot and massage ▪ Keep the foot warm ▪ Light exercises	▪ Frequent and increasing in intensity symptoms ▪ Fixed timing of pain ▪ Unable to perform daily chores

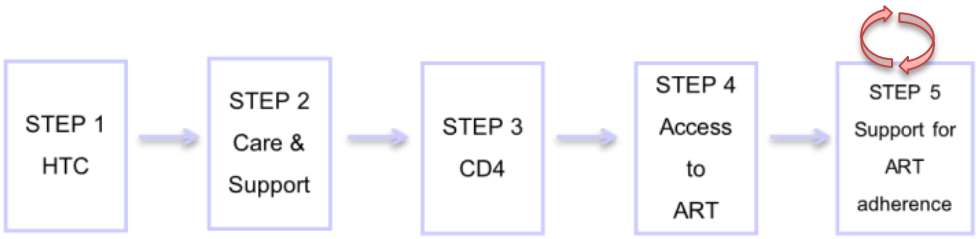
ARV Adverse effects		
Pallor/Anemia	Home self-care	See a doctor when
	▪ Increase animal protein intake ▪ Increase intake of green legumes and colored fresh vegetables ▪ Supplementary edible iron intake	▪ Weakness for 3-4 weeks and or increasing weakness ▪ Postural dizziness and giddiness and easy fatigability
Easy fatigability and dizziness	Home self-care	See a doctor when
 	▪ Fixed sleeping hours and time ▪ Exercise regularly as tolerated ▪ Eat fruits and vegetables ▪ Stop smoking, and all other substance abuse ▪ Cook nutritious food	▪ Unable to eat or severe weakness ▪ dysphagia
Skin Rashes	Home self-care	See a doctor when
	▪ Proper hygiene avoid perfumed soap ▪ Try for a clean and dry skin ▪ Apply lotion for itching ▪ Avoid Sunlight exposure ▪ Increase water intake	▪ Fever ▪ Sore throat and red eyes ▪ Chronic rashes ▪ Vesicles and papules or discharge.

ARV Adverse effects		
Jaundice	Home self-care	See a doctor when
	▪ Drink lot of fluid ▪ Proper rest ▪ Avoid fat ▪ Drink 800 ml to 1200 ml of sweetened fluid.	▪ Jaundice increases ▪ There is fever ▪ Loss of appetite weakness ▪ Increase in abdominal girth leg swelling
Diarrhea	Home self-care	See a doctor when
	▪ Frequent small servings meals ▪ Easily digestible nutritious food ▪ Plenty of fluid ▪ 1-2 packet of ORS ▪ Avoid salty and oily food	▪ Blood in stool ▪ More than 4 watery stools per day ▪ fever ▪ Unable to drink fluid
Nausea and vomiting	Home self-care	See a doctor when
	▪ Consult with physician about ARV with meals ▪ Frequent small serving meals ▪ Plenty of fluids and ORS ▪ Avoid salty and oily food	▪ Stomach pain ▪ Fever ▪ Blood in vomit ▪ Vomiting for more than 1 day ▪ Unable to drink

ARV Adverse effect		
Nightmares	Home self-care	See a doctor when
	▪ Avoid uncomfortable activities before sleep ▪ Stop alcohol, smoking and other psychoactive stimulants ▪ Relax with chit chat ▪ Avoid heavy meal before sleep	▪ Sleeplessness for many days ▪ Extremely scary nightmares

Chapter 6

Support for ART adherence



STEP 5: support for ART adherence

After starting the ARV treatment, regular follow up is essential to assess treatment outcome and side effect from ARV. The indicator for treatment outcome is viral load (VL) and CD4 cell count. ARV therapy needs strict adherence and regular follow up with CD4 count and VL count to monitor the therapy, usually VL should be or less than 50 viral copies/ml after 6 months of therapy.

Case managers' role for ART adherence:

Drug adherence is important after the initiation of treatment. Case managers have important role in providing care and support to help client in taking ARV regularly. For clients that are just starting an ARV routine, case managers should advise that they call for a consultation when they miss a dose.

After the ARV treatment has been initiated, case manager should establish regular follow-up. The follow-up procedures to improve ARV adherence is as following.

1. Follow up with the client
    I. Ask general information about the client's life
    II. Explore client's emotions
    III. Ask about their ability to adhere to ARV treatment. Are they could take their medication at regular intervals? Have they missed any doses? What are the barriers to taking ARV regularly?

2. Follow-up with the service providers
    a. This follow-up mechanism could take place when the case managers have established a connection with health care providers. This mechanism would help the three parties (client, health care providers and case manager) in improving the quality of care, benefitting the clients with a better treatment outcome. This follow up aims to assess the following issues.
        i. Assess if the client receives the treatment regularly
        ii. Assess if the client has any problems? Are there barriers to the treatment?
        iii. Case managers might offer help to health care providers by coordinating or providing home visits to clients to help them develop better adherence strategies.
3. Follow-up the CD4 and viral load results.
    a. Monitor and record CD4 and viral load counts. Has CD4 increased and viral load decreased?
    b. Help the client's understanding of the results by interpreting the results and link them with the client's behavior in taking ARV.

The three follow-up procedures mentioned above help the case manager obtain thorough information about the clients, and help in planning appropriate strategies and in preventing clients from dropping the treatment.

The table below is an example for follow up

Time span	Activity
1st month	Phone contact and follow-up
2nd month	Contact through social applications, Line, Whatsapp, etc.
3rd month	Follow up through phone for ARV appointment
4th to 5th month	Social applications / Line
6th month	1. Follow up through for ARV Rx 2. Meet with client

	3. Meet the client during different activities of the organizations 4. Visit clients individually 5. Meet clients at their health care unit's.
7^{th} to 11^{th} month	Social applications
12^{th} month	Contact clients to maintain relation and avoid loss of follow up.

Emotional care and support:

Various emotional responses could happen to people living with HIV, although the clients might be physically stable. Although the emotional response from clients are varied, there are general feature that can be anticipated (Department of Mental Health, 2003.)

Uncertainty: As clients lives with uncertainty in that there is they don't know if they will be affected by the side effect of ARV, they don't know how the disease will progress (getting better or worse), they don't know if they will got opportunistic infection, they might be worried that their family will know that they have HIV infection. If their family knows, will they accept?

Shame: After living with HIV for certain duration, client starts to accept their sero-status. However, the doubt if other people understand if they know the sero-status, or if they know about their gender. The more the clients do not want to disclose their status, the more shameful they will be.

Guilt: Clients might suffer self-guilt due to their past deeds. They might blame themselves for not being responsible to their family. Client's suffering from self-blame can be precipitated when they experienced discrimination from other people who know the client's the sero-status.

Sense of worthlessness: Because adaptation with difficult situation needs time, the client's emotion might fluctuate between feeling valuable and feeling worthless. During the time when clients' mood is down, they might think that they don't have any strength, or they are stupid, or worthless.

1. Case Managers must have knowledge about emotional response in PHIV, and understand that they might have experienced difficulties suffering emotional instability, due to difficult circumstance that happens around them.

2. When client suffer emotional instability, case managers should help the clients to explore their own idea, feeling and expectation. This will help clients have a better understanding about themselves, and become more stabilized.

3. Case manager should help the client early when they starts to have negative thoughts/feelings. However, when helping the clients, case managers should aware that the help is not to make the client be dependent but to be able to stand on their own.

Case Managers role:

1. Confidence building between clients and case managers for a fruitful, trustworthy case manager-client relationship.
    a. When case managers express that they understand the client and is ready to listen, it allows the client to express his/her feeling in-depth.
2. Help the clients to face reality by using open-ended question to help them explain their fear and worries i.e.

Case manager: What if you disclose this issue with your family? How will your family react? (Open-ended question)

Clients: I really don't know maybe it won't be as bad as I have been expecting or maybe they might hate me who knows…..

Case manager: Will everyone hate you? What family members do you feel closer to? Who of these family members would be the most empathetic? (The case manager needs to challenge the client's thinking and fears. At the same time, case managers need to prepare the client to be ready for any reaction from family members and anticipate the possible consequences of disclosure).

3. Help the client to develop positive attitudes, e.g. not blaming him/herself or others. Help them learn to forgive. Help them look forward to the future and move ahead with their life.

Drug Adherence

Adherence

Regularly taking prescribed medicine (adherence) means the patient (here client) understands and decides to follow the prescription strictly. Adherence in ARV therapy is very important because HIV have a special ability for developing drug resistance and increased cell replication with missed doses.

Good adherence

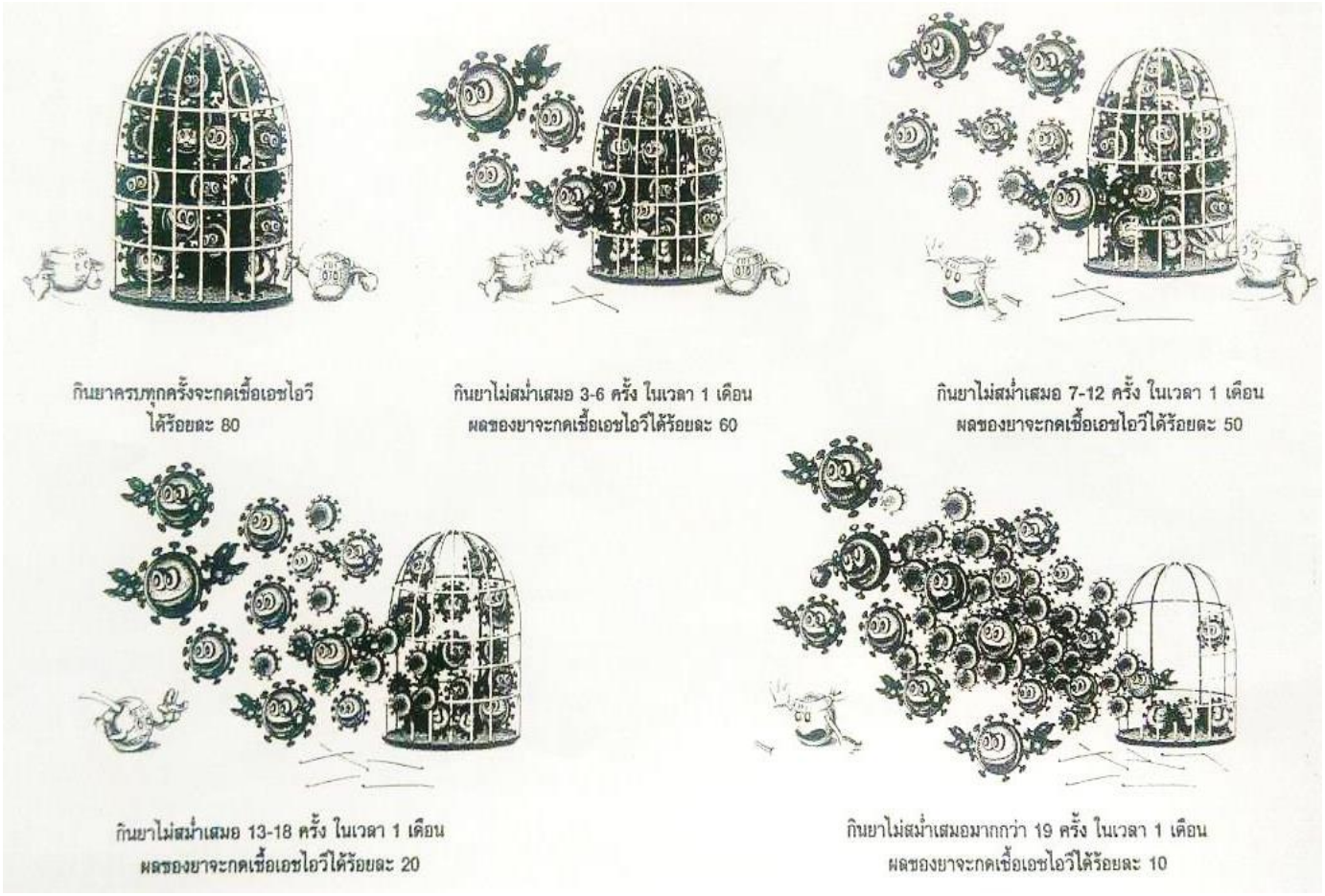
Patient who agree to and actively participate in planning of ARV treatment with physician then strictly follow the prescription no more than 5% of dosses missed per month and per dose no later than 30 minutes of the fixed time. (BATS, 2011)

Doses and the fixed time e.g. every 12 hours then it is every 12 hours

- **At the appointed time every time, no later than 30 minutes after.**
- **Missed doses must be taken as soon as remembered, except if the next dose should be taken within 2 hours or less, then take the next dose at the appointed time.**

The picture below explains the following

- No missed doses in a month will suppress HIV by 80%
- 3-6 missed doses in month ARV potency reduced to 60%
- 7-12 missed doses in a month ARV potency reduced to 50%
- 13-18 missed doses in a month ARV potency reduced to 20%
- More than 19 missed doses in a month potency reduced to 10%
  (BATS, 2003)



Noncompliance to treatment produces drug resistance in HIV, necessitating treatment regimen change. (BATS, 2010)

- Treatment regimen change usually brings in different sets of adverse effects from which clients had been suffering, treatment costs rises
- Modification of lifestyles in accordance of the regimen will be necessary
- If there is any doubt, questions contact the prescribing physician or case manager.

Factors which affects adherence (Phanu , 2557)

1. Symptoms and medication side effects: ARV therapy produces a varied adverse effects which create problems for clients, in particular the headaches, skin rashes, dizziness nausea and vomiting makes clients feel their health have worsened in place of getting better since ARV initiation and many of the clients stops themselves.

2. **Stressful Life events**
   Stressful events may include loss of livelihood, loss of residence, imprisonment, or being the victim of abuse. Visits to a hospital for treatment or hospitalization can also cause anxiety, depression and noncompliance to ARV treatment.
3. **Family and Social support**
   Receiving social support from people who are important to the client will enable adherence. Clients feel that there is meaning for living, they have someone who loves and cares them. This supporting mechanism helps client to have better self-care, because they want to live longer.
4. **Complexity of drug regimen**
   The more complex the regimen is the harder it makes for the client to achieve good adherence. For example, if the client has to take many different tablets at different doses and at different times a day, it will be more difficult for the client to adhere to the regimen.

5. **Self-efficacy**.

Self-efficacy means the client is confident in taking ARV, and believes that they can take ARV correctly, regularly and continuously. Some clients don't have self-efficacy simply,

because they are not confident that they will be able to take the medicine continuously. Thus, case managers should support clients' self-efficacy that they are capable to achieve good adherence

Chapter 7

Care and Support: emotional and spiritual well being

Care and support for emotional and spiritual wellbeing that is provided to the clients comprises the following components.

1. Building relationship
2. Listening skills
    a. Content
    b. Feelings
    c. Need(s)
3. Questioning skills
4. Simple reflection(reflecting the content)
5. Reflection client's true meaning or feeling
6. Supporting: encouragement
7. Changing attitudes by reasoning

Techniques and methods for providing care and support

A number of techniques have been employed in care and support services provided by community based organizations. In general, case managers use various techniques in the provision of care and support services, which are adapted to the needs of different clients. Certain techniques that are employed include: client-centered methods, motivational interviewing, cognitive approach counseling, reality therapy, and logo therapy.

Access to professional counseling services for Thai people remains limited in comparison to access for other professional services, as there are limited professional counselors. In addition to this, people perceive that receiving counseling sessions with a psychologist or other health professionals means that they are are incapable or have psychiatric problems. Hence, there are benefits to the provision of counseling services by case managers ***Case managers*** position themselves as a ***caring and supportive friend***. Case managers make clients feels comfortable to talk with, to share experience and to tell the problems, like they are talking with a close friend who walks with them through their path. The detail of skills needed for emotional and spiritual care and support are as follows (Pongpan, 2004):

Relationship building

Building relationship(s) is a foundation of care and support work. In the first encounter that the case manager and client meet, they will start to assess whether or not they will be able to work together. Developing a good relationship in the first encounter is a key for the success of the work between the case manager and the clients. The first meeting should happen in a casual, warm, friendly manner, thus, make the client be confident that they shall continue growing the relationship and work with the case manager.

Listening skills

Listening is one of the most important skills for case managers providing care for PHIV. Listening is the door for understanding; it helps case managers getting information about the client's life, feelings, and needs. Listening can be divided into 3 levels:

- **Listening to the content of the client's story:** case manager listens to the story or information about client's life: what he/she does for a living, where he/she lives, who he/she lives with, what is his/her past experiences,
- **Listening to the client's feeling:** client's feeling is around the story that he/she tells. The feelings might be expressed in words i.e. "I am so glad that my parents understand me". Feeling might be expressed through body language such as eye contact, tone of voice, facial expressions, and body movement. For example, case managers might notice that the client is happy and proud of himself when he talks about his career success through his facial expression and the tone of his voice.

Feelings can be separated into 2 parts: positive feelings and negative feelings.

Positive feelings	Negative feelings
glad, proud, love, fun, excited, relieved, confident	Sorry, shameful, discriminatory, fear, worried, unstable, in confident

- **Listening to the client's needs:** this level of listening is have and in-depth of understanding about what client needs, what he/she wants or what is his/her expectations. Often, the client doesn't know what he/she wants, so case managers can help by reflecting to help the client in finding out what is his real need or expectation i.e. love, acceptance, understanding, peace.

Positive feelings	Negative feelings
Because something he/she has got something that is needed	Because he/she does not received what he/she needs
Feeling happy because he/she is loved	Feeling worried because he/she is not confident that people will accept

The picture below explains the level of listening, and how case manager can understand the clients.

Questioning skills

Questioning is a way the case manager use to get information from the clients for example his background, interest, occupation, and etc. This information helps case manager understand more about the client's context, his problems and main concern. While questioning helps case managers to get information, it helps the client to understand better about themselves. It helps them review their life, their thoughts and feelings. Case manager can use general questions that help them explore their ideas, feelings, needs and expectations.

In general, there are two types of questions: Open-ended questions and close-ended questions.

Open-ended questions	**Close-ended questions**
1. The questions give the clients opportunity to answer in many different ways. For example: "How have you planned your future?"	1. The questions have limited the answers with yes or no. For example: "Are you a MSM (man who has sex with other men)?"
2. The questions may start with "what, when where why or how"	3. The questions provide the client two options. For example: Are you the penetrative or receptive partner in sex?
Utility of open-ended questions	**Utility of close-ended questions**
1. It provides clients with an opportunity to explore their ideas and understand more about themselves.	1. It helps in confirmation on specific issues
2. Case manager has an opportunity to learn more about the client from the answers.	2.It helps case manager in checking whether he/she understand the client correctly

Simple Reflection

There are various type of reflection and generally can be divided into 2 groups that is simple reflection and complex reflection. Simple reflection can be performed in many different ways such as repeat, rephrase or paraphrase. The meaning is exactly the same to what the client's has said.

Clients: Now, I don't know what to do. There are so many things have happened to me. I don't know where to start from.

Case manager: -There are so many things happen to you (repeat)
- You don't know where to start from (repeat).
- Many things happen to you (rephrase)
-You don't know where to start because there are so many things that happen to you (paraphrase).

Reflection client's true meaning or feeling

Reflection of feeling is when case manager try to understand the client's feeling from what the client is saying and then reflects his/her own understanding back to the client.

Client: Now, I don't know what to do. There are so many things have happened to me. I don't know where to start from.

Case manager: You are overwhelmed, not knowing where to start.

The benefits of reflection include the following:

1. It help the client to review his own idea after hearing his/her own sentence from the reflection by case manger
2. It helps the client understand better his/her own feelings.
3. It makes case manager in checking that he/she understands the client correctly.

Supporting skills

Providing encouragement and supporting self-efficacy is essential and there are many ways of providing support, either with verbal or non-verbal communication, for example, expressing with thumbs up and touching on the shoulder. However, sometimes case manager need to be careful not to give the client a false hope and make the client be unrealistic

Client: What should I do…I don't know how I can tell my family about my sero-status. At the university people will discriminate me and what about my future…I don't know how I can continue living …everything seems to be so bad to me.

Inappropriate way of providing support

Case manager: Everything will be ok (You don't really know what is going to happen, so it's not a good way of providing support)

Appropriate support

Case manager: Now you are feeling overwhelmed, not knowing how to deal with the coming problems (Reflecting feelings). We will think together to find the way solving the mentioned issues. (Supporting)

Affirmation is another way of providing support in which it is not only an encouragement but provide the client with confidence in how they are or what they are doing.

Client: Right, everybody has his/her own problem, but what is more important is how he/she deals with it.

Case manager: You are right, everybody has his/her problems, but how he/she deal with the problems is more important. (Simple reflection by repeating what the client says and affirmation)

Client: Did you say that you will help me solve the problem?

Case manager: We will explore ways that these problems might be solved together. (Supporting, providing confidence that they are not alone)

Changing attitudes

Sometimes, client might face a lot of problems and he/she might start to have negative attitude, being pessimistic, and exaggerating. The case manager needs to help the client develop realistic and rational attitudes through the use of reason. The technique used here are adapted from "reality therapy" and "cognitive approach to counseling" which emphasis on client's ideas and reasoning mechanism. The case manager helps the client review his/her own thoughts, challenges him/her thinking based on reality and change his/her attitude. This skill is normally used when case managers are experience and developed certain relationship with the client.

Client: What should I do? How can I tell my family that I have got HIV and what about the university? My friend will look down on me. I won't have any future. Everything is so terrible! My parents will hate me if they know this. It's done, and I have nothing left in my life!

Case manager: In the past, when bad things happen to you, how did your parents react? (Questioning to make the client think and be rational, instead of being pessimistic)

Client: There was one time, when I had a car accident and hit other people on the road. My father complained a lot, but my mother kept crying. She was worried that I had a serious injury.

Case manager: From your opinion what do you think? Why they have those reactions?

Client: They might be tired of me. I didn't listen to what they kept teaching me. But, I kept bringing them problems.

Case manager: Could there be other reasons that made them upset? (*Questioning to help client think about other possible reasons, being rational by linking to the client's story)*

Client: They must be worried about me. They are worried bad things could happen to me, because they love me so much.

Case manager: Yes, they love you. So, what if you tell your mother first? (Giving affirmation, helping the client looks at the positives).

Client: I will make her disappointed in me.

Case manager: You are worried that if you tell her you will make her sad. (Reflecting)

Client: Yes, I don't know how to start.

Case manager: How have you thought about telling her? (Open-ended question to make the client think, review and start to plan)

The conversation above is example of some part of the conversation between the client and case manager, using various technique to help the client understand better about him/herself.

The conversation help the client explore his/her feelings and start planning. In the example, the conversation starts with the client's negative thoughts and feelings, not knowing where to start solving the problems. After the dialogue, it reveals that the client is worried about

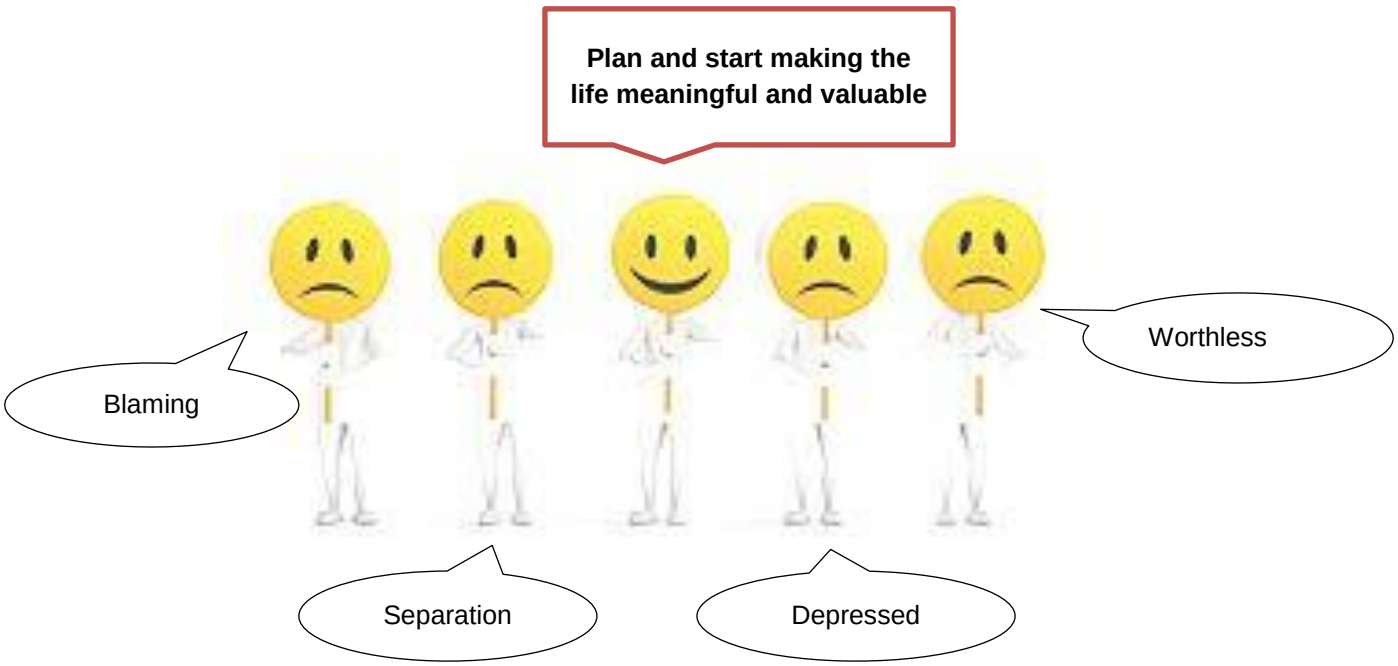
disclosing his HIV-status to his parents and feeling helpless. Case manager helps the client realize about his/her concern, be rational and start planning to solve the problem by him/herself.

Essential knowledge for case manager

Care and support for spiritual wellbeing (Aranya, 2010)

Care and support for spiritual wellbeing mean supporting the client to be peaceful, hopeful, believing in love and faith. Enable them to continue doing good deeds; being generous, having mercy, being glad with others' happiness, helping and forgiving others, helping others to be successful (transcendence). This part involves ethics and morals which develop from family and culture in the community in which they live. It develops from experiencing love, understanding, accepting, respecting, and supporting others equally as members of a community. A harmonious community is where people help each other, and everybody having equal rights, without any discrimination, making a peaceful place to live. Such communities enable spiritual wellbeing, which doesn't mean that there is no problem but the community will find the way to help solving the problem and eventually find a new balance (Kanika and Panus, 2012).

The work by the case manager on care and support for spiritual wellbeing for PHIV involves finding the meaning of life. Case manager helps the client find the meaning of their life, by reviewing what has happened to the client in the past and his/her suffering during those time. This will helps them identify what was their expectation. Case manager help the client learn that the suffering is an opportunity for the client to make the achievement even more valuable, in which it makes the life meaningful. Case manager help the client to have hope be fulfilled and having goal in their life. The opportunities is there and it is the client who make his/her own choice.(Aranya, 2001)



Changing attitudes when facing difficult situation is new opportunity for the clients, because when they live with HIV they start to realize about uncertainty in life and start planning better. This critical situation is an opportunity that helps them find new value and meaning of life. When they find the real meaning for being born; they will lead their life in meaningful way not only for him/her but for the family, and society.

Case managers should be sensible, observing clients, as each would have different progress towards finding the meaning of life. For those who remain suffering, not being able to lead their life meaningful, case manager needs to provide more care and assess if they have risks of self-harm or suicidal idea.

Characteristics of client who need assistance to lead their life meaningfully are as following.

1. Separation
2. Getting bored, loss of creativity, loss of interest
3. Obsess with the problem and being pessimistic
4. Feel worthless, discouraged and lonely
5. Having no direction
6. Having suicidal idea

Techniques to help clients

Being obsessed with one's own story, particularly those negatives thoughts won't help the client solve the problems. The longer the client remains with the negative thoughts the worse the spirit will be. Case manager should help the client with the following methods.

1. Ask the client to stop thinking about self, separate his/her thought away from him/her.
2. Direct the client to new thoughts by bridging to other issues and have positive ideas.

Sometimes the client's thoughts keep repeating like a cycle and don't help changing anything. That is because the client is not ready to change or solve the problem. Case managers should help by asking them stop thinking about the problem for a while, and replace the thoughts about the problem with other things. This is not to escape from the problem, but to rest for a while and face it when the client is more ready

Example:

Client: I have been thinking a lot and could not understand why this has happen to me? Why I am so unlucky. I tried to find the way out, but I could not. It's so dark. I really don't know what to do. I don't know how I can live anymore.

Case manager: If you cannot find the way at the moment, why don't you stop thinking about this for a while? Is there other thing that you should think about? (Deviate the client from present thought, by asking him/her to think about other issues.)

Solving the problem when the client is not really ready could lead to new problems and make a difficult issues turn to be even harder to solve. Asking the client to stop thinking for a while to rest and be more ready is an option that the case managers should offer to the client.

3. Changing attitude is changing the way of thinking for the same situation by providing the client free of choice that it's him/her who directs his/her life.

Change the attitude

When keep being obsessed with a sad story, the client starts blaming, either him/herself or his/her destiny. Changing the way of thinking and start acting is a way to help the client find the way to help the client seeing new options and solve the problems.

Questioning skills is used to help the client change the way they think

Questioning examples: What are some things that you think you can do that make your situation a little better? (open-ended question)

The example of the questions used above alter the client thoughts in that it make them think about other aspects and could eventually help them change his/her focus.

Example:

Client: I was thinking and couldn't understand why this happen to me? Why I am so unlucky? Why me? Or was I really bad in the past life, so I am punished now? What should I do in the future?

Why I am so unlucky? I don't have anything left….I don't know how I can live anymore? How can I face other people? It will be a stigma for all my life.

Case manager: What happen in the past it was because you weren't aware of the risk, but what is going to happen to you from now on depends on you. You can choose to design your life the way you want it. (Changing focus of the client)

Setting goals

Setting goal is the work between the case manager and the client to find the goals in the client's life. Most people have many goals, not just one. However, if there is one big goal, the case manager should help the client define smaller goals/milestones that are involved in reaching the large goal. The goals vary with many factors such as personal experience, stage of development, context of his/her life, such as for some people the goal might be completing a degree, saving money for travel.

Case manager should not drop any goal that the client proposes; however, the case manager must have the client determine whether each goal is realistic or not.

Goals can be divided into 2 groups: Short term and long term goals

1. Short term goals: things that the client plan and expect it to happen in short term i.e. within 1, 3 or 6 months.
2. Long term goals:

Planning to achieve the goal

In making a plan, case managers should help the client to make a clear plan for the goal they would like to achieve. Emphasize that the goal should be realistic and achievable. If the plan or goal that is set is too hard to achieve, it might be discouraging for the clients to move ahead with the other plan. Thus, the goals set should be realistic and start doing step by step to achieve each goal. When the client is successful with an initial simple easy target, success with the initial goal will empower him to continue and keep going. Eventually, the difficult goals are achievable.

Example:

If the client found that his/her goal is to take care of his mother, case manager should help the client find the way to plan his/her life to be able to take care of his/her mother.

1. Goals are things that the client set to achieve. In setting goals, there should be behavior to make it tangible.

   Goal: taking care of mother

   Behavior:

   - call his/her mother every day
   - Return home every holiday to spend time with her
   - Send her money every month
   - Take her around every month
   - Take her for health check up

After setting the goals, the client should assess the feasibility of the plan. For example, if the client set the goal that they would like to visit his/her mother every week, it would not be realistic if the client and his/her mother live in different province or very far away. Therefore, case manager should help the client review the plan, to make sure that it would be feasible for a longer term. This ways is also helpful in terms that the client learns that things need to be realistic. When they plan to solve any problem, the plans need to also be rational and feasible to achieve.

2. Barriers are things that inhibit the client to do things they planned to do

   Barriers:

   - the price of the trip to visit his/her mother unexpectedly increase during the holiday
   - Not having enough money left to send to his/her mother every month
   - Not knowing how long he/she can live as the client is affected by HIV.
   - Not being able to live with his/her mother as he/she is ill by HIV

3. Problem solving refers to measures that the client would use to solve any problems that happen. Case manager should help the client assess and plan the problem solving him/her self, by asking him/her to think and plan how they can achieve his/her dream as plan.

Barriers	Problem solving
Not having enough money to give his/her mother every month	Save more money each month
	Reduce the shopping and tourism
	Plan to do more work to earn more money, so he/she can have enough saving for the future
Having good health living with HIV	Take care of his/her self, lead a healthy life-style, eating good and healthy food, using condom and lube regularly, follow up with the doctor regularly

The planning that has been made by the client by case manager support will eventually help them find the way to solve the problems. It makes the client see the barrier clearer, and make them know what they need to do to achieve their goals.

Rewarding /Empowerment is the methods that case manager uses to support the client confidence and self-efficacy. It can be used in many situations, for example, when the client succeeds their little goals.

If the client calls his/her mother every day for 2 weeks they can reward him/her self with a good Japanese meal.

Rewarding helps the client to be motivated to continue with the plan and always willing to achieve new goals.

Chapter 8

Care and Support: Social wellbeing

Social care and support is another pillar of PHIV care and support. Care and support for social wellbeing is the services that help a person connect with other people and receive support from the system in the community. Social care and support enable a person to live harmonious in the society with equal rights, justice and peace. Social care and support promote healthy relationships between the client and his/her partner, friends, colleague, and community. In this chapter, the explanation of care and support for social wellbeing will be divided into 3 levels (Kannika and Panus, 2012):

1. Individual level: refers to the care and support to ensure equal rights and justice is received from society.
2. Family level: refers to care and support that helps a person connect with other family members in order to share love, care and support from the family.
3. Societal level: refers to care and support that enable a person to connect with other people in the society. A harmonious society is where people can share and live peacefully, in spite of differences in ethnicity, culture, religious beliefs, and sexual orientation.

Care and support for social wellbeing at Individual level

Get access to health care services under National Health Coverage scheme.

The services divided into 2 groups, for those who don't know their rights in getting health services, and for those who already have access to their health care benefits (The POZ Home Center 201-, Nitisak, 2014).

- Clients who are unaware of their registered health unit or have never used the services of NHSO: For example, people who never use health services before, or those who have been registered under universal health coverage in other province.
    c. Check their registration: use the Thai national ID card number and find out from NHSO web site. www.nhso.go.th/peoplesearch

- Clients, who are aware that their registration is with a health care unit in a different district will need to get their registration transferred. Case managers can assist the

client in transferring their registration. To do this, the following documents will be needed:

i. A copy of the rental agreement with client's name or the name of a roommate as the tenant (if a roommate is the official tenant, the roommate should provide an affidavit stating that the client resides at the mentioned address and verified by the landlord);.
ii. A copy of the client's housing registration
iii. A copy of the client's Thai National ID card, and, if a roommate is the official tenant, a copy of the roommate's ID card will also be needed;

- Care provider along with client then contact any NHSO office in the District offices (please check beforehand whether the district office have NHSO desk or not).
- The transfer is done and announced on the website on every 15th and 28th of the month.
- Case manager or the client can call 1330 NHSO help desk to follow up the status of the transfer.
- Case manager can help get the client access or be referred to specialized secondary or tertiary medical facilities

Transfer of NHSO/NSSO registration.

- Clients, who are aware of their rights and know where they should be registered, can check their registration at the medical facilities on the website.

If the client is happy with the health facilities (convenient/ accessible for the client) at which they are registered, they can that health facility for treatment.

If the client wishes to get transferred, they can follow the following procedure.

<u>NSSO health coverage scheme</u>

1. NSSO transfer the registration between 1st January and 31st March of the year, midyear transfers are possible only when there is a job change or home address change.
2. Cases where employers select the hospital for their employees, Human Resources (HR) officer will have to be notified for a transfer of registration.

3. Clients who turn unemployed can continue using the access to health services for 6 months after losing the job. If the registration under social security scheme is expired, client can transfer and use NHSO- universal health coverage scheme.

<u>If client need transfer the registered hospital during the year, follow the steps below:</u>

1. If the client changes his/her job, he or she can inform the human resource department about their need their registration to another health care facility/hospital.
2. If the client does not change the job but change his/her home address, bring the document related to their new home/address (rental agreement or new housing registration) to get the transfer processed.
3. If the client neither changes his/her job nor his address, his/her rights could not be transfer until Jan-March of the following year.
4. When the client changes the hospital, the client needs to request his/her medical file from the previous hospital. When attending the new service, he.she should bring his/her medical history, referral document, and ID card.
5. The registration and rights for the health care services can be checked through the following hotlines: NHSO is 1330 and NSSO is 1506.
6. When the client gets the new registration, the client should first contact the primary care unit to get an initial assessment before a referral to a secondary or tertiary care.

Thai PHIV's rights for access to ARV treatment can be divided into 3 schemes

1. Universal Health Coverage, managed by National Health Security Office (NHSO)
2. Social security, managed by the National Social Security Office (NSSO)
3. Civil servant health coverage, for civil servants

he detail of the benefit package that is covered by universal health coverage is as in the table (NHSO, 2013)

Guidelines for Laboratory testing and initiation ARV		
Anti–HIV		**2 times a year**
Baseline laboratory (CBC, FBS, Cr, Chol.,TG, SGPT/ALT)*		
After the initiation of ARV)		
· PHIV under 35 years without underlying diseases		once a year
· PHIV under 35 year with underlying diseases		twice a year
· PHIV 35 years or more		twice a year
CD4 count		
ARV not initiated		
· CD4 > 500 cells/mm^3		once a year
· CD4 350 - 500 cells/mm^3		twice a year
After the initiation of ARV		
· CD4 > 350 cells/mm^3 and VL < 50 copies/ml		once a year
· CD4 < 350 cells/mm^3 and VL < 50 copies/ml		twice a year
Criteria for ARV initiation	**CD4 level (cell/mm^3)**	**Recommendation**
AIDS defining illness	CD4 at any level	initiate ARV
**Clinically positive symptoms	CD4 at any level	initiate ARV
asymptomatic	< or = 350	initiate ARV
asymptomatic	> 350	Not initiated ARV need to check CD4 count every 6 months
Viral Load(VL)		
Only after ARV initiation		

· After ARV initiation until VL < 50 copies/ml · VL < 50 copies/ml · Suspicious drug resistance a. Taking:1 hour away from the schedule (more than 2 times) or taking ARV irregularly **b.** Having Opportunistic infection	Not more than twice a year Once a year Can repeat VL if required by physician (but not more than 2 times a year)
Drug Resistance · VL > 2,000 copies/ml while taking ARV · Or after stopping ARV for less than 4 weeks	Not more than once a year

**CBC is complete blood count, FBS is fasting blood sugar level, CR is creatinine, Chol is Cholesterol, TG is Triglyceride, SGPT(ALT) is Liver enzyme.*

*** Clinical symptoms refer to oral candidiasis, PPE, prolong fever, chronic diarrhea (more than 14 days), weight loss for more than 10% in 3 months or having simultaneous herpes simplex infection in 2 locations.*

The coverage of HIV treatment services covered by the National Social Security Office (NSSO) is as in the table

CD4 testing-
NSSO will reimburse 500 Baht per test but no more than 1,000 Baht per year.

Viral Load (VL) testing-
NSSO will reimburse 2,500 Baht per test but no more than 5,000 Baht per year.

Drug resistance testing-
NSSO will reimburse 8,500 Baht per test per year.

ARV treatment is provided for-
-PHIV with CD4 less or equal to 350 cell/cumm^3
-AIDS defining illness including prolong fever, diarrhea for longer than 14 days, decrease body weight for more than 10% within 3 months
-If the client received ARV before registering under social security scheme, the client can

continue with the initially prescribed medicine. However, this regulation is only applied to basic cARV regimen, other regimens will have to be sought and prescribed by HIV specialist.

Civil servant benefit package or others equivalent

The benefit package provided for civil servant is provided in the “Manual for Reimbursement of Health Care Benefits for Civil Servants, Ministry of Finance.” However, the details of reimbursement in each different case may depend on the office management at the client’s civil service post.

In general, there are two methods of reimbursement. One way is the client can ask the hospital that they received the treatment to directly reimburse from the ministry of finance. Another method is that the client pay the treatment in advance and then get reimbursed later. (If the medicine that the client received is on the essential drug list, the client does not need to provide the details of the medicine received to the office.) Sons or daughters of civil servants can use civil servant benefit package if he/she is under 20 years old.

Legal rights of People living with HIV (BATS, 2011)

In Thai law, nothing is specifically written in the law for PHIV. However, the rights of PHIV are covered in the constitution under the law for human rights protection.

1. The client’s rights for confidentiality and privacy
a. Client could not be forced to get HIV test and disclose the test result and to disclose the test result to other people
    i. HIV is counseling and testing needs to be voluntary and the clients have to receive counseling before and after getting tested. Coercion force of any kind is illegal.
    ii. Service providers cannot provide the client’s name or other information, including the test result, to other people without written consent
b. Sharing client’s test result
    i. Sharing information about the client can only happen if there is written consent.

ii. If a hospital or other health service provides the HIV test result to the employer without the client's consent, the hospital is breaking the constitutional code 3 and criminal law code 323
iii. Anybody that opens the client's test result without permission from the client is acting against the law criminal law code 322
iv. Carelessness, resulting in other people knowing the client's test result is failing to follow the civil law code 420.
v. Telling others about the test result without the client's consent is breaking the constitutional code 34, criminal penal code 323, and civil penal code 420.

2. The client's rights to education and employment. All people have equal rights to education and employment. PHIV have the same rights in using public utilities as other people.
    i. Firing employee due to his/her HIV status is against the constitution code 30. PHIV who can still work with his/her full capacity have equal rights and opportunities for career development.
    ii. The following acts are considered as violation of human rights: forcing employee to get HIV test, discrimination, disclosure HIV status, for example among others.
    iii. A PHIV has the right to access to education and benefit from it. Neither public nor private institutes should discriminate against PHIV. PHIV shall follow the same regulations as other students.
3. Rights to marry and build a family

    Things that are considered as inhumane include the followings.
    i. Prohibiting PHIV from getting married or building a family.
    ii. Forcing pregnant women and children to get tested for HIV
    iii. Mandatory abortion, because the either the pregnant woman or the father is infected with HIV or both parents are infected, citing HIV infection as the reason for abortion.
    iv. Forcing PHIV to get sterilized

Reporting Human Rights Violations

PHIV can lodge their complaints at the Office of national human rights commission of Thailand. Hotline 1337, or

Through the website: http://www.nhrc.or.th/2012/wb/th/petition.php?menu_id=4&groupID=2

- **Obtaining compensation from National Social security office for lack of income** (NSSO 2556)
  Client registered under NSSO health scheme are entitled to a paid sick leave for 30 days in a calendar year following doctor's advice. Social welfare and Labor law govern this. If doctor's advices for longer sick leave, NSSO will compensate the lost income, known as "Compensation for lost income" accordingly clients will be paid 50% of their salary as compensation equivalent to no more than 180 days in a calendar year and no more than 90 days at a time, Chronic diseases* are compensated for 365 days in a year. Compensation will be paid for the remaining periods in a calendar year and only after client's employer stopped paying the salary.

  Documents needed:
  1. Use a specific form of the NSSO office
  2. Medical Certificate
  3. Letter of Guarantee from Employer
  4. Copy of national Identity card or other document issued by government
  5. Numbers of sick leave taken by the patient
  6. Documents requested by official to aide in decision

  *HIV/AIDS is under chronic diseases, according to

http://www.sso.go.th/wpr/content.jsp?lang=th&cat=868&id=3647(

- **Government financial support for PHIV** (office of HIV AIDS, TB and STI 2554) the details are as follows
  1. Support in a form of allowances are paid by social welfare department of Municipal authorities or local tambon authorities, this is only for those PHIV who are registered residents of the municipalities or tambons.
  2. Family support is paid by provincial Department of Social welfare and center for Human resource development.
     Documents needed

- Copy of National identity card
- Copy of house registration
- Medical certificate with HIV positive lab result

Family level social care and support

Case manager services provision for social care and support at family level aim is to help the client connect with their family, where care and support could naturally is provided.

Disclosure:

Disclosure is an important issue in which case managers may need to be involved. Case managers may need to assist clients in making the decision on whether or not to disclose their HIV status to partners and/or family members.

Disclosure of HIV sero-status is a difficult decision for PHIV to make; they can keep it secret or disclose it. The role of the case manager is to help the client to think about the pros and cons and leave the final decision to the client.

Some community-based organizations have developed forms to help guide the client through the decision-making process. The form below is the form used by CAREMAT (CAREMAT, 201-).

Benefits from disclosing 1. 2.	Barriers to disclosure 1. 2.
Benefits from not disclosing 1. 2.	Barriers to disclosure 1. 2.

Table: Example of a client's assessment on the pros and cons of the disclosure and non-disclosure

Choice	Advantages	Disadvantages
Disclosure HIV/STI status	• No burden of secrecy • Can ask for and receive emotional support • Easier access to health care and to take your own medications (don't have to hide them) • Able to talk about symptoms and worries • If disclosure to one's spouse/partner, can openly discuss safer sex and family planning choices • Can share reasons for specific activities (e.g. breastfeeding/replacement feeding) • Partner can be tested and receive treatment • Other	• Distancing or outright rejection by partner/spouse/friends • Possible loss of job* • Children shunned in school* • People believing person is promiscuous • Discounting the person due to fatal illness* • Assumption that all signs or symptom are HIV-related* • Fear by others for their own safety around the person* • May be at risk of mental and/or physical harm • Other * Associated with HIV discrimination & stigma
Non-disclosure of HIV/STI status	• Maintain "secret" • Maintain status quo i.e. "normalcy" or current situation • Protection against stigma, isolation, rejection, loss of income, violence, blame of change in social status • Being prevented from having children in the future • Not needing to seek medical care • Other	• Burden of carrying secret • Anxiety due to fear of involuntary disclosure • Unable to access social support • Isolation • Risk to other sexual partners • Delayed access to medical care • Loss of trust from children/family • Other

The role of case managers in providing care and support to couples or sexual partners has two phases.

1. Disclosure of HIV sero-status to partner or partners
2. Living together after disclosure of HIV sero-status

Disclosure is an extremely sensitive and important event in a life of a PHIV. The impact of disclosure can change the life of PHIV altogether. The case manager's role is to help the client to make the decision on whether or not he/she should disclose their sero-status.

Case manager role in the first phase is to ask the client about disclosure of HIV sero status to partner, and then discuss the pros and cons with clients. The table below enumerates some of the point which can be discussed.

Table: Prepare the client to plan the methods to disclose and be ready for the consequences.

To Whom	Reason	Method	Consequences	Ways to cope
Partner	1 wishes the partner to know 2 to cope with the guilt feeling 3 wants partner to take the HIV test.	1 gradually place HIV text books for partners to see and read 2 Refuses sexual contact without condom 3 invite partner for HIV testing	Partner is angry	Apologies
			Partner denies and do not believe	1. Tell partner firmly that it is the truth. 2. Tell the partner to take HIV test, so he/she can receive treatment early
			Partner ends relation	1. Accept the reality, let him/her go. 2. Take care of yourself and use condoms/safety measures when having sex to prevent re-infection

Disclosure is essential due to the following reasons

1. Allow partners to have early access to treatment and care;
2. Reduce HIV transmission to uninfected individuals;
3. Prevent re-infection of HIV and STI; and
4. Reduce the risk treatment resistance

Case manager should explain the client the benefits of disclosure

- Disclosure will help the client negotiate for protection with partners and thereby help the client protect him/her self from possible re-infection with other strains of HIV, including drug resistant strains.
- The client can spread HIV and other STIs even though he/she may be asymptomatic Therefore disclosure can help encourage partners to get tested, know their results and receive early treatment, if necessary.
- If client's partner does not realize that he/she has risk of HIV infection, he won't get an HIV test.
- The client can get re-infected with STIs if the partner is infected and does not get treated.

Options for disclosure to a partner or family member(s):

1.1 Client discloses him/herself.

1.2 Client takes their partner to the hospital and discloses it himself in the presence of a counselor.

1.3 Client takes their partner to a hospital and let counselor disclose in the presence of client (written consent is needed).

1.4 Client consent to (written not oral) counselor disclosing the HIV sero-status in the absence of client (client waiting outside the room)

1.5 Client discloses to a trusted person and let that person tell it to his partner.

Case managers' role when the client is not ready to disclose

Case manager need to suggest preventive measures to prevent the client from getting additional infection and simultaneously he/she also need to prevent spreading the infection to his/her partner.

-highlight the need to use condoms or practice non-penetrative sex

-the client need to take ARV regularly to control HIV replication

Social level Care and support

The aim of care and support at social level is to connect the client with the society. A healthy society is a society that people in the community are connected, supportive and accept each other although they are different from each other.

- **Group support activities**

Group activity is a way to build relationship between people in the community, joining in a group activity helps PHIV feel that they are a part of the society who can express their idea, feeling and can make contribution.

Some examples of group activities organized by community based organization are:

1. Family day: An activity that organized for PHIV for them to have a community where they can meet people and share their experience, organized by the POZ Home Center.
2. Good life workshop: An activity organized for PHIV for them to share their ideas and feeling from the situation in their life, so they understand better the disease they live with and, at the same time, learn that they are not alone. There are other people who understand their situation and are ready to help. The workshop is organized by the HIV Foundation.
3. Educational group activities to provide knowledge about HIV, CD4 and ARV. Educational group activities are generally organized in groups of 20-30 or smaller. Various community based organization such as CAREMAT, SWING, SISTERS, RSAT and MPLUS organize educational group activities.

- **Group activities to promote society understanding towards PHIV**

Apart from group activities for PHIV a lot of activities have been organized to promote understanding towards PHIV and reduce stigma and discrimination.

Example

1. Group activities that bring HIV negatives with PHIV together: These activities can help change people's attitude, because the activities give people an opportunity to share their ideas. Eventually, it helps them learn that they can live together in the society.
2. Activities to build occupational skills for income generation / livelihood.
3. Entertainment activities that gather people together are another channel that help normalize HIV.
4. Activities that bring the client's sero-negative partner or family members together in order to help them have better understanding towards PHIV and to help them learn to live together.

Chapter 9

Care and Support: Visiting Client

Visiting client outside the services unit (community based services center/drop-in center) is another important part of case managers' work in providing care and support to the clients. The work on visiting client can be divided into 2 types:

1. Visit at an external venue, outside the community-based office
2. Home visit

In principle the visit could be performed only with the client's consent and the case manager feels comfortable to conduct the visit

Visiting Client at an external venue:

These visits are away from the community-based services facility or drop in center, but not in the client's home. This is conducted when cases managers initially assessed and feel the need for a face-to-face meeting, but the client cannot come or feels uncomfortable to come to the drop in center. Common reasons for an external visit include the following.

- Client is under extreme stress due to multiple problems and client lacks an advisor in their time of need.
- Client requires help for health care services.
- Client needs to discuss about medical condition or needs.
- Sometimes care provider feels the need for visit from the information provided by client.

Sometimes, external visits for care and support might take place in a hospital, i.e. when the client is receiving treatment/admitted. Before making a visit, case managers need to prepare for the visit by doing the following:

Preparation to visit:

1. Review and assess the need for visit
2. Contact client through phone
3. Request for permission to visit and fix the place and timing
4. Remind the client few days and few hours prior the appointment
5. Plan and prepare the visits and record all visits.

During the visit

1. Introduce each other

2. Establish rapport
3. Explain the need for the visit and role of the case manager
4. Emphasize the confidentiality of the information discussed and documented.
5. Ask for consent and or if the client is comfortable with the visit.
6. Assess the need for the care and support as well as severity of the problem. The case manager helps the client in the assessment of his/her own problems.
7. **Plan the care and support intervention and help the client to find the solution for his/her problem.** The plan must be detailed including what to do when to do how to do. The plan should be developed by mutual agreement between the client and case managers. Sometimes, case managers might need to use various counseling techniques to help the client move forward. For example, motivational interviewing might be used to help client move towards behavioral change. When clients are depressed or have negative attitudes, case managers might help using client look on other aspects and change the attitudes.
8. Make referrals to specialized services when necessary.
9. Make a follow-up appointment, this is essential, so case managers can follow-up the following issues.
    a. The result of the previous care and support session. What happen to the client after the plan has been initiated? What are the barriers to make things happen as planned?
    b. What was the result of the referral, if referral was made?
    c. Does the client have other problems/obstacles that haven't yet been discussed?
10. After providing care and support, the case manager should keep a record of what was discussed in a form: the services provided and the plans that have been initiated.

For many cases, external care and support service visits can take place in the home of the client. This will be described in detail in the following the next section.

Home visits

Home visit is another procedure that case manager use for the care and support services. The aims of home visits are as following.

1. Confidence building exercise
2. To counsel family members and relatives about life with PHIV
3. Illness evaluation
4. Relation building between case manager and family members
5. Risk assessment for the client and family
6. Follow up to treatment

There are 4 types of home visit

1. **To assess the current status** of clients with regards to physical and mental health, and to assess family relationships and the environment in which the client lives.
    - To assess the barriers the client has in accessing services e.g. CD4 count, ARV treatment.
    - To assess the effect of ARV on client's daily life and to assess if his//her.
    - To assess whether the client has a full understanding about his/her right to access treatment and if the family members understand and support the client
    - To assess the home environment for the client's wellbeing
    - To assess relationships inside the family, i.e. if the client is well integrated into the family and community.
2. To provide basic health.
    i. This could be acute illness such as when client have fever. Case managers might provide basic health care, such as measure the body temperature and sponge bathing to help reduce the temperature.
3. Post hospital discharge after receiving treatment from a hospital, case managers have role in helping client to develop and adherence plan with the medication he received.
4. End of life home visit, case manager role is to provide emotional support, and help with the work on the documents on declaration of death and benefit that the government may provide to the family.

Steps for home visit services

There are 4 steps in conducting home visitations: Preparation, services provision, review the visit and planning for continuous care.

Prepare to visit:

Preparation depend upon the purpose of the visit, still case managers should follow the following steps for the preparation.

1. Review client's information to assess the need and objective for home visit.
2. Arrange an appointment and ask the client to consent to a home visit.
3. Prepare the tools that will be needed: trip map, client's file folder, thermometer, dressing set, disposable gloves, torch, and etc.
4. Confirm the appointment with client

Visiting the client at home:

An acronym INHOMESSS is used to guide case managers on the services that should be provide.

I = Immobility: assess the client' activity of daily livings if he/she can normally take care of his/herself i.e. showering, dressing, toileting, eating, sleeping. If not, who is providing the care, and how the caregiver copes with the stress?

N = Nutrition: assess if the nutrition the client is having is appropriate for his health condition, and if food preparation is hygienic.

H = Housing: assess if the environment in the house is appropriate for the client's condition, and if it promotes the client's mental wellbeing

M= Medication: assess if the client could take ARV and other medicine consistently and correctly, If not, what are the barriers and how can the client adjust?

E = Examination: examining client's health in general if he needs additional support or if he needs referral

S = Service: where does the client receive health and social services, and what are the services that case manager should provide

S= Safety: assess if the home environment is safe for the client

S = Spiritual: what are the beliefs and values of the client and family

After the assessment, case manager has a role in providing care and support for the client, as in the following example.

- Help the client arrange the ARV doses, making it easier for the client to take the right doses at the right time.
- Engage the family in helping the client with his medicine.
- Providing emotional support to the client, the caregiver or to other family members.

- Motivate the client and family to tidy up the house to make it clean and livable.
- Coordinate with primary care or secondary care services if needed.

Review the results from the home visit

Review of the visit should be done along with staff members shortcomings/problems should be resolved.

Planning for continuous care

Individualized long-term care should be formulated according to the visit.

Home visitation services help the client get access to care and support when they are not ready to receive hospital services. The case manager helps providing support to the client at home and co-ordinates referral of the client to other needed services, to ensure that the client’s needs are met.

Essential knowledge for case manager

Basic nursing care for common problems

FEVER:

Fever means body temperature higher than normal. Fever can be checked by placing the back of the hand (opposite of palm) on the forehead. The forehead feels warmer than the back of the hand. Patients can complain of headache, body aches, malaise and shivering (if fever rapidly rise and remits).

The most common cause of fever is infection; it can be due to flu, common cold, Pharyngitis, Tonsillitis, in PHIV fever can be due to opportunistic infection

- Pulmonary TB (PTB) or Tubercular Lymph Node Adenitis (TB LN). PTB must be the first suspect in client complaining of cough more than 2 weeks and solid, small, smooth growth in and around neck, axilla (armpits) and inguinal area (groin).
- Pneumocystis carinii pneumonia (PCP): the main complaints are increasing difficulty in breathing fever and dry cough.
- Cryptococcal meningitis:, the main complaints are fever with headache, neck stiffness and generalized reduction of muscle power (inability to move)

Case managers should advise for transfer to a health care unit whenever case managers sees the above sign and symptoms. Basic Nursing care is cold sponging and Paracetamol 500 mg 1 tablet every 4-6 hours but never more than 10 tablets in 24 hours.

Temperature is measured by thermometer by three methods.

1. Oral, 3-5 minutes normal temperature is 37.5
2. Armpits 5 minutes add 0.5 to the reading to get true temperature
3. Anus 2 minutes the normal temperature is 37.5

Any reading above 37.5 is considered as the person is running a fever.

<u>Fever reduction by sponging</u>

1. Prepare a three liter water tub and four pieces of clean clothes (preferably cotton fabrics)
2. Take off all of the client's clothes
3. Place one soaked cloth each on forehead and the two armpits use the fourth to mop the body particularly the chest, abdomen and both upper and lower limbs. The palms and foot should get longer attention.
4. Turn the patient and repeat the sponging on the backside

5. Re-soak the cloth at the forehead and armpits and replace the cloths and repeat the process of sponging.
6. Dress the client in dry loose fitting clothes.

Diarrhea:

Diarrhea means number of stool's passed per day is more than normal for the patient; it could be soft, watery, bloody and or with mucus, acute onset, acute on chronic or chronic.

Causes:

1. Acute diarrhea is mostly due to food poisoning (Food-borne Gastroenteritis) patients (clients) will complain of watery stools with or without nausea vomiting abdominal pain. Fever with diarrhea means patients need antibiotic therapy. Usually the diarrhea should resolve in 3-5 days.
2. Chronic diarrhea (more than 3 weeks) can be a side effect of treatment or infection or both. Others causes include cancer of the intestines; some types can be fully cured. Incurable diarrhea will need symptomatic treatment.

First up case managers must assess the hydration status of clients

a. Mild dehydration - mild weakness and yellowish urine.
b. Moderate dehydration - mild weakness some dizziness giddiness, yellowish urine increased thirst but otherwise normal.
c. Severe dehydration - sunken eyes, dry mouth and skin, weakness prominent, if accompanied with heart rate more than 120 beats/minute. Blood pressure lower than 90/60 mm of Hg means impending shock so that the patient will need massive and rapid rehydration shift the patient to a nearest health care unit.

Mild to moderate dehydration can be home nursed by case managers with

1. Counsel for low fiber, high protein and high protein diet.
2. Avoid deep fried food, fresh vegetables, pickled fruits, spicy foods, and foods that may cause intestinal gas.
3. Advise fluid intake of 3 liters or more per day or ORS (factory made or homemade) homemade ORS can be prepared by
    a. A glass of drinking water
    b. A spoonful of sugar
    c. A pinch of table salt

4. Advise for frequent but small meals
5. Top notch hygiene particularly the anal and groin region
6. Wash the hands with soap and clean water after each visit to the toilet.
7. Diarrhea with fever, diarrhea with mucus and or blood or dizziness on movement warrants a visit to a doctor.

Sore Throat and Sore mouth:

Sore throat and mouth is common in PHIV with a wide range of symptoms, from self-limiting to incurable chronic symptoms.

1. Sore throat can be due to common infections such as Pharyngitis or oral ulcers or fungal growth in poor immune PHIV (CD4 < 300 cells/mm^3)
2. Aphthous ulcers
3. Oral Herpes
4. SLE or tumors can cause dysphagia and sore mouth and throat too.

NURSING SUPPORT:

1. Oral hygiene is the most important aspect in sore throat or mouth treatment. Regular warm water gargle, teeth brushing 3-4 times a day helps to keep the mouth clean and lowers the intensity of the symptoms.
2. Eat meals at room temperature and avoid spicy meals.
3. Soft bland foods can help protect the oral mucosa.

COUGH:

Coughs can be productive (with sputum) or dry (without sputum). Coughing may be continuous or intermittent coughing. Coughing may also occur with blood.

Causes:

Usual diseases such as Rhinitis or PTB PCP are the common causes of coughing in PHIV.

PCP, pneumonia caused by Pneumocystis Carnii, causes symptoms of dry cough with difficulty breathing and high fever. Symptoms may range from mild to severe.

PTB may cause coughing for more than 2 weeks with yellowish sputum, which is produced mostly after waking up. PTB may also cause weight loss.

Other causes of coughing include bronchitis to Lung Cancer.

NURSING SUPPORT:

1. Common colds and flu can be treated symptomatically at home with fluid and rest.
2. Common nursing provided can be frequent change of sleeping position
3. Sipping of lukewarm water with lemon
4. Clapped the back with a cupped hand to help loosen secretion in the chest before meals to avoid aspiration
5. Side pillow to reduce chest pain during coughing episode.

Refer to a Doctor:

1. if cough persists 2 weeks or more
2. High fever
3. Dyspnea
4. Sputum with blood or puss.

Annexes

Annex 1: Case support planning for positive health (FHI 360, 2012)

Case support planning: for positive health[6]

Client/Patient Number: **Today's Date:** _ _ _/ _ _ _ _/_ _ _ _

Date of original HIV diagnosis:

1. Medical follow-up

For newly diagnosed clients or clients new to your service.

Has the client seen a HIV doctor since they were originally diagnosed HIV positive?

❒ YES Date: ❒ NO, Reason?

When was the last time that you saw a HIV doctor? Date:

What has the doctor (or nurse) told you about your health? (Brief note)

Did they give you any medicine to take? Details

Are you experiencing any difficulties with taking the medication (correct dose, correct way, and correct time)?

[6] Adapted from Counselling Tool 4.6, Post-diagnosis follow-up counseling form, HIV Counselling Training Package, Family Health International, UNICEF EAPRO, WHO WPRO & SEARO, February 2010.

2. **Wellness –** Medical review and general observations required. Liaise with treatment doctor in relationship to required tests or health screen.

Routine Laboratory Tests

- ❑ CD4 Count
- ❑ Viral Load
- ❑ Resistance test
- ❑ Complete Blood Count (CBC)
- ❑ Chemistry Panel
- ❑ Toxoplasma IgG
- ❑ Blood Fats
- ❑ Blood Sugar
- ❑ Pap Smear
- ❑ Tuberculosis
- ❑ Urinalysis
- ❑ Tests for Sexually Transmitted Infections
    - ❑ Syphilis
    - ❑ Gonorrhoea
    - ❑ Chlamydia
    - ❑ Human Papilloma Virus (HPV)
    - ❑ Other
    - ❑ Hepatitis tests
        - ❑ Hepatitis A
        - ❑ Hepatitis B
        - ❑ Hepatitis C

Vaccinations

- ❑ Human Papilloma Virus (HPV)
- ❑ Hepatitis

- ❑ Influenza
- ❑ Measles, Mumps and Rubella

General medical review/notes for follow-up

3. Brief psychological assessment

Over the last month (existing patients) or since patient diagnosis (newly diagnosed patients)

Has the client experienced any of the following?[7]

(tick the appropriate box):

- ❑ A persistent sad, anxious or "empty" mood
- ❑ Too little or too much sleep
- ❑ Reduced appetite and weight loss or increased appetite and weight gain
- ❑ Loss of interest or pleasure in activities once enjoyed
- ❑ Withdrawing from friends, relatives or others they are normally close too
- ❑ Agitation, restlessness or irritability
- ❑ Persistent physical symptoms that don't respond to treatment (possible indicator of health anxiety disorder)
- ❑ Difficulty concentrating, remembering, or making decisions
- ❑ Hallucinations (hearing voices or seeing things others cannot hear or see)
- ❑ Fatigue or loss of energy
- ❑ Feelings of guilt, hopelessness or worthlessness
- ❑ Thoughts of death or suicide (briefly note the thoughts)

4. Social and welfare

Does the client/patient experience difficulties with any of the following:

[7] If the client/patient experiences five or more of these symptoms for longer than two weeks or if the symptoms are severe enough to interfere with their daily routine. Conduct a more detailed assessment if you are a psychiatric nurse, psychiatric social worker or psychologist; if not refer to a doctor or a qualified mental health professional.

Accommodation	❒Yes	❒No	Details:
Finances	❒Yes	❒No	Details:
Obtaining food, medications	❒yes	❒No	Details:
Relationships (partner, family, and friends)	❒yes	❒No	Details:

5. Positive prevention

5.1 Partner disclosure

Already disclosed ❒Yes ❒No

Notes on outcome of any disclosures / reasons for non-disclosure:

Future disclosure plan

- ❑ Client/patient will self-disclose
- ❑ Client/patient would like to disclose in presence of counsellor
- ❑ Counsellor to disclose on behalf of client/patient without the presence of the client/patient (who must complete signed release of information)
- ❑ Client/patient wishes counsellor to disclose in his or her presence
- ❑ Client/patient will disclose to a trusted third party and request that individual to make disclosure on the client/patient's behalf.

5.2 Transmission risk reduction:

Use of condoms

- ❑ Doesn't use condoms with any sexual partners
- ❑ Condoms used with regular partner only
- ❑ Condoms used with all partners EXCEPT regular partner
- ❑ Condoms used with ALL partners

Does the client/patient indicate that s/he has difficulties with sexual functioning?

Yes ☐ No ☐

If yes (Indicate which)

☐ Arousal ☐ Difficulty maintaining erection ☐ Difficulties with ejaculation

Does the client/patient indicate that the above-mentioned problems make it difficult to use condoms? Yes ☐ No ☐

Does the client/patient indicate that s/he is using any sexual performance enhancing substance (e.g. sildenafil / Viagra®)?

Yes ☐ No ☐ ……..If yes, what?

Details of any treatment or referrals the client/patient has received or requires:

Has the client/patient used any non-prescribed drugs (including hormones and steroids) and/or alcohol in the last month?

Yes[8] ☐ No ☐

Has the client/patient been prescribed any hormones or steroids in the last month?

Yes ☐ No ☐

Sharing needles and equipment ❒Yes ❒No Details:

Drug dependency assessment or management referral required ❒Yes ❒No

(Refer to the International Classification of Diseases (ICD) website: http://www.who.int/classifications/icd/en/

Pregnancy

Client/patient is pregnant ❒Yes ❒No NA❒ Partner is pregnant ❒Yes ❒No

If Yes, stage of pregnancy

☐ 1-3 months ☐ 4-6 months ☐ More than 6 months

On ARV prophylaxis? ❒Yes ❒No NA❒

Client/patient's partner uses contraception regularly ❒Yes ❒No NA❒

Family planning referral required: ❒Yes ❒No

Pregnancies test referral required: ❒Yes ❒No NA❒

Client/patient support plan (attached) has been completed ❒Yes ❒No

[8] If yes, please conduct the detailed "Drug and Alcohol Assessment" available in the Toolkit.

Release of Information signed for referrals ❒Yes ❒No NA❒

Additional counseling notes:

Counselor signature

Name of patient casework coordinator

Date:

Client/patient support plan

Key Issues	Considerations / support strategies

Annex 2: Treatment Adherence checklist and summary record form (FHI 360, 2012).

Treatment Adherence checklist and summary record form

Patient's name/code…….. Medical record#.....

Date of counseling session……

Review patient's understanding of HIV/AIDS:

- ☐ What is HIV? AIDS?
- ☐ Opportunistic infections
- ☐ CD4/Viral load
- ☐ Patient's understanding of his/her health status
- ☐ Effect of treatment
- ☐ Need for adherence (explain)

Review barriers to adherence and progress made:

- ☐ Poor communication
- ☐ Low literacy (e.g., cannot read medication instructions)
- ☐ Inadequate understanding of HIV/AIDS
- ☐ Lack of social support
- ☐ Failure to disclose status
- ☐ Mental state
- ☐ Travel or work difficulties

Review the treatment program and importance of adherence:

- ☐ Drug regimen
- ☐ Dummy-pill demonstration
- ☐ What ART does (e.g., improves immunity, less OIs/ART, but not a cure)
- ☐ Relationship between non-adherence and transmission resistance clearly explained

- ☐ Side-effects and what to do
- ☐ Follow-up visits
- ☐ Importance of adherence and consequences of non-adherence

Review interactions with ART and possible treatment resistance

- ☐ Alcohol and non-prescribed drug use
- ☐ Treatments for sexually transmitted infections
- ☐ Use of hormones (e.g. .oral contraception, gender reassignment, hormone replacement therapy)

Review proposed adherence promotion strategies:

- ☐ Buddy reminder (discuss role of support person)
- ☐ Other reminder cues
- ☐ Review the treatment program and proposed adherence promotion strategies for patient with drug or alcohol dependency referred for detoxification or oral substitution therapy

After patient <u>has commenced treatment</u> refer to items on the reverse side of this form

Add for ongoing follow-up visits:

Review patient's experience with treatment and adherence over the past month

- ☐ Drug regimen and adherence – pill counts, self-reports
- ☐ Discuss side effects and actions taken
- ☐ Discuss need for continued prevention
- ☐ Discuss follow-up plan for next month
- ☐ Review patient's goals and success at achieving them

Explain the need for collection of emergency contact details. Record phone and address details in patient file. Discuss procedures for protection of privacy.

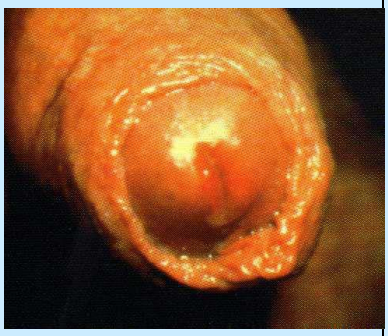
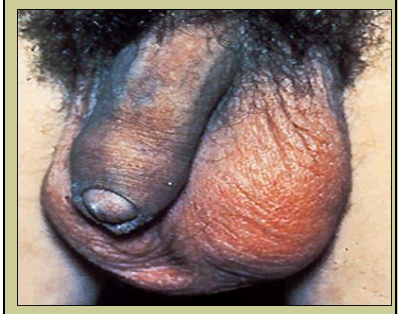
Schedule next counseling session and complete appointment card

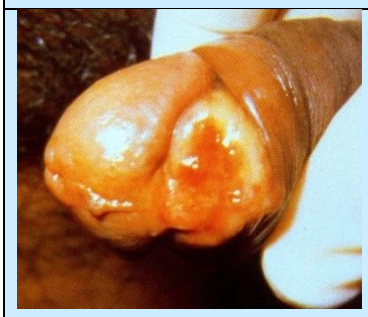
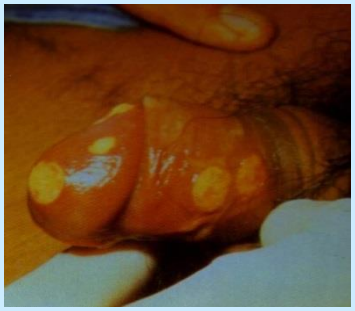
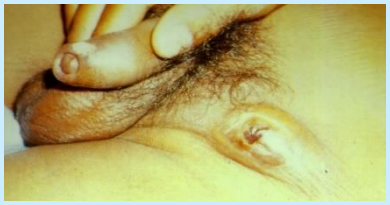
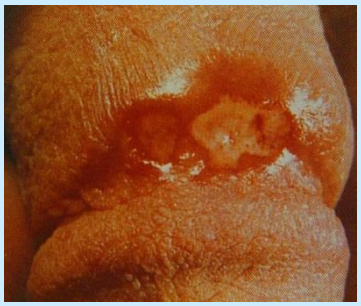
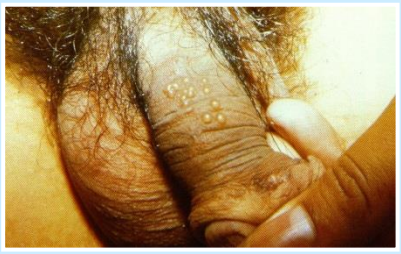
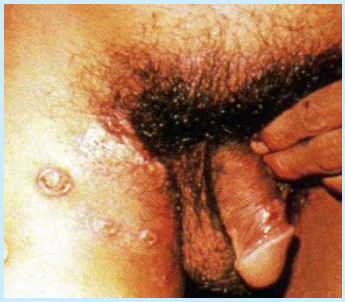
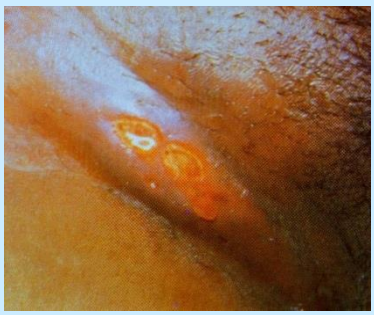
Refer to dispensary or pharmacy

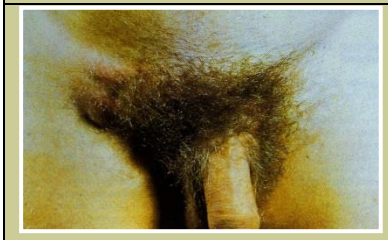
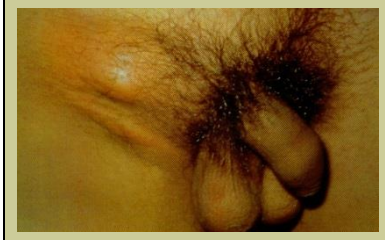
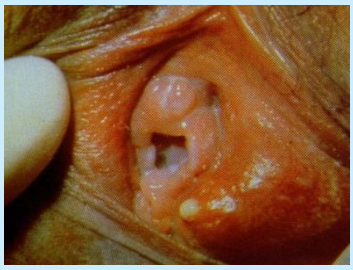
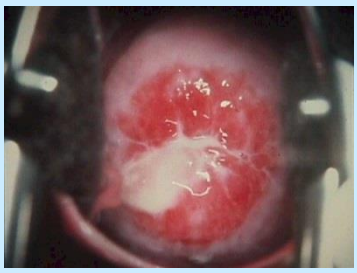
Nurse / counselor's signature……..

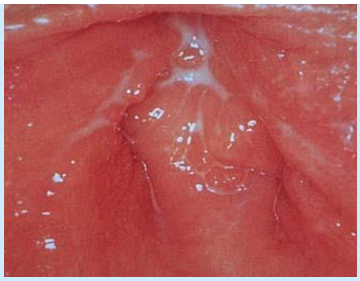
ANNEX 3: Infection that can be sexually transmitted

Table: Common presentations of client with STIs and causative organisms (FHI 360, 2555)

Complaints	SIGN and Symptoms	Causative organisms
Pus discharge from male penis		
	- Abnormal discharge during or after urination	- Neisseria gonorrhea
	- Itching sensation - Frequency - Painful micturition -	- Chlamydia trachomatis
Inflammation of Sexual organ is due to untreated STI		
	- Pain and swelling in and around sexual organs.	- Neisseria gonorrhea

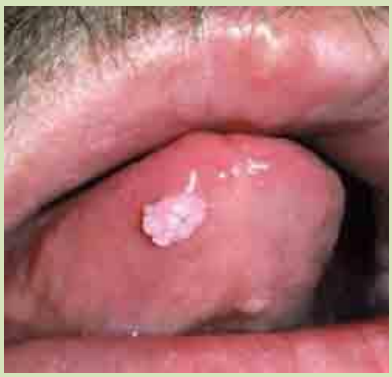
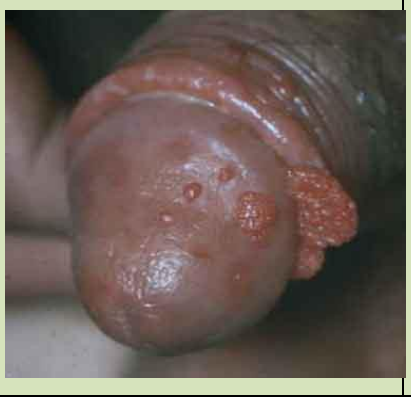
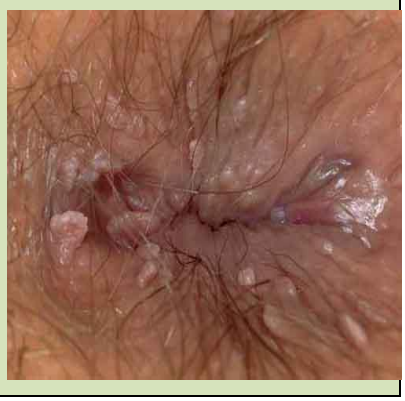
Ulcers, furuncles around sexual organs (the pictures below)		
	- Painless or painful ulcer on penis	- Treponema Palladium
	- lymph node swelling genital herpes 	- Haemophilis Ducreyi
	- ulcers or open wound on penis - genital herpes 	-
	Lymph node swelling painless or painful with or without secretions around inguinal area and sexual organs genital herpes	- Klebsiella inguinale
		- Chlamydia infection

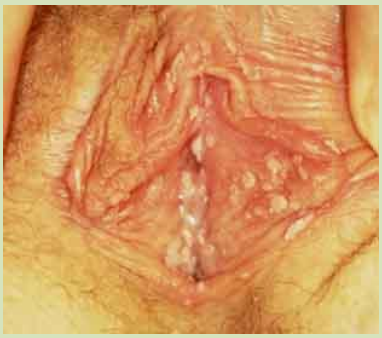
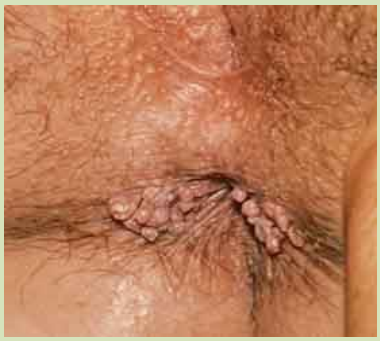
Lymph node swelling and growth		
 	- Inguinal lymph node swelling	- Haemophilis Ducreyi - Chlamydia Trachomatis
Vaginal Discharge		
  	- Abnormal vaginal discharge - Painful micturition - Pain during or post coitus - Vaginal itching - frequency	- Neisseria Gonorrhea - Chlamydia Trachomatis - bacterial vaginitis - Candida Albicans

		- Trichomonas Vaginalis usually transmitted from male sexual partners.
Pelvic Inflammatory diseases	- Lower abdominal pain Radiating to the back pelvic area and inner thighs, can be continuous or at intervals - Fever can be high continuous (acute or advance stage) or low grade fever when modified by inadequate treatment.	- Neisseria Gonorrhea - - Chlamydia Trachomatis - Anaerobic bacterial infection

Genital Warts:

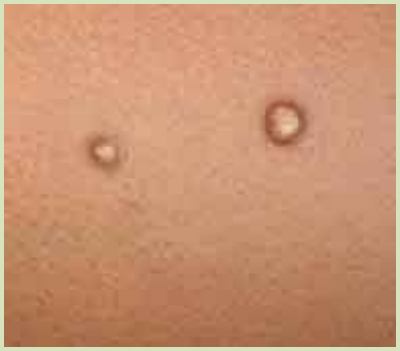
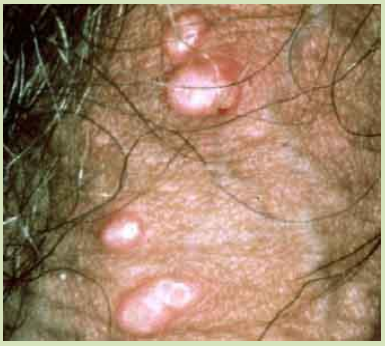
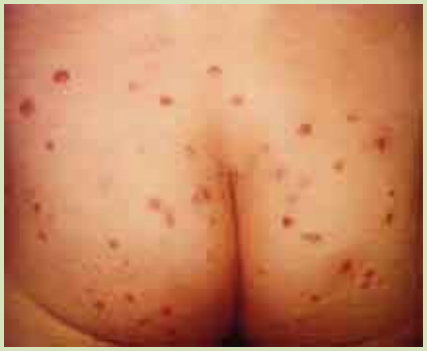
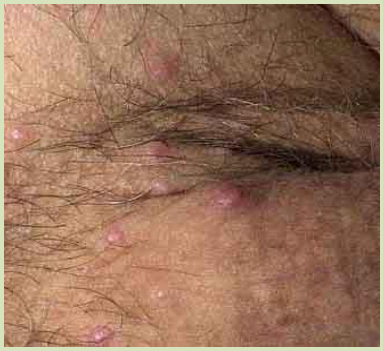
Genital warts by HPV are mostly by sero-type 6, 11 with a 28% chance of the cells becoming cancerous.

Oral	Penile	Anal
		

Oral	Vaginal	Anal
		

Molluscum contagiosum:

Found in MSM and TG in form of rounded 1cm diameter growth or mass.

Superficial skin infection	Male sexual organ infection	
		
Deep skin infection	**Female sexual organ infection**	
		

Syphilis:

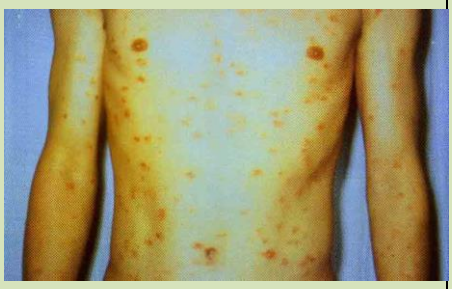
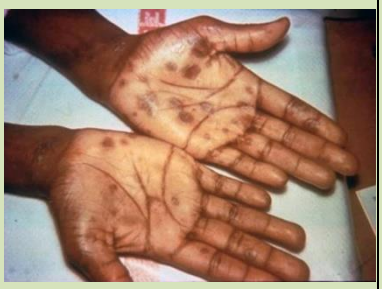
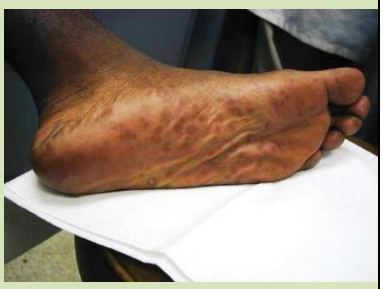
Syphilis, one the oldest known disease, is common in MSM and TG the pathophysiology can be divided into 4 stages

1. Primary stage: this can be assessed by chancre if client develops a chancre at the primary entry site (sexual organ) it can be painful or painless or fluctuate between the two, left untreated chancre resolves itself and patient enter secondary stage of syphilis
2. Secondary stage: This stage patient is contagious the symptoms vary a lot from discrete asymptomatic patches to small nodule at the palm and foot or groin, low grade fever is common. High fever with pharyngeal lymph node infection may be present or it may manifest as weight loss, hair loss, around half of the patients remain asymptomatic throughout. (they are contagious regardless of symptoms)
3. Latent stage: if left untreated patient enters into latent phase, patients are symptomless and the period ranges from 10 to 20 years with average of 12 years when patient enters tertiary stage.
4. Tertiary stage: here syphilis manifest as skin infection or deep tissue infection or neurological infection this is the most difficult stage to treat due to complexity involved.

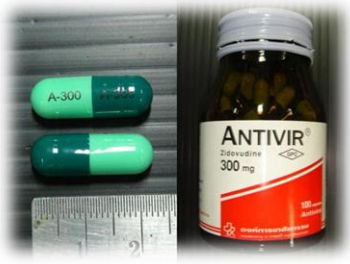
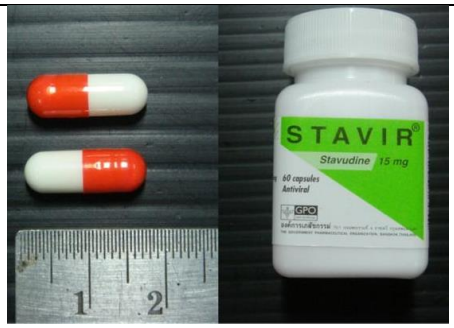
Treatment of Syphilis differs from stage to stage. Few points' case managers should always keep in mind

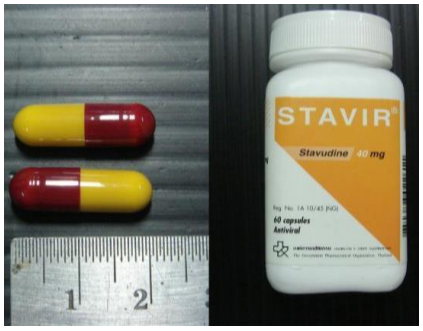
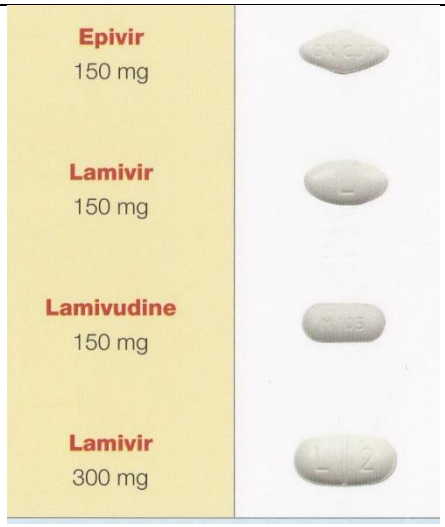
1. No home treatment, self-treatment, Herbal treatment, Spa treatment, etc. will cure Syphilis, it can only be cured by proper Antibiotic for proper duration.
2. The treatment will cure Syphilis but will not repair the damage done by Syphilis.
3. Absolutely no sexual contact till full cure is achieved.
4. All sexual partners must be traced notified and treated.

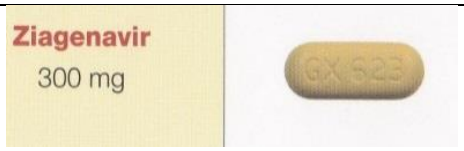
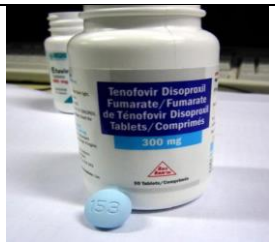
The treatment of syphilis would vary according to the stage of the disease. The treatment of primary stage syphilis would be an intramuscular injection or taking oral antibiotic for 14 days. For those with later stage(i.e. with latent period for longer than 2 years will need to received injected antibiotic weekly for 3 weeks or taking oral antibiotic for 30 days(Angkana, 2010)

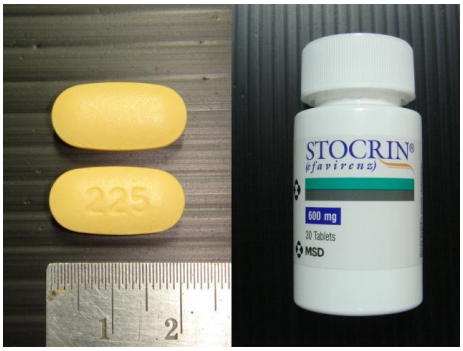
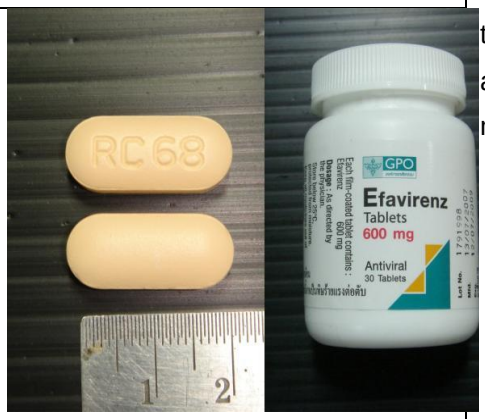
Second stage syphilis on skin	**on Palms**	**On dorsum of the foot**
		

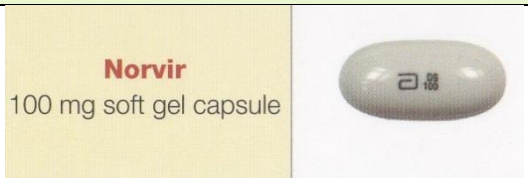
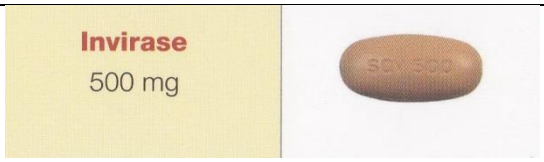
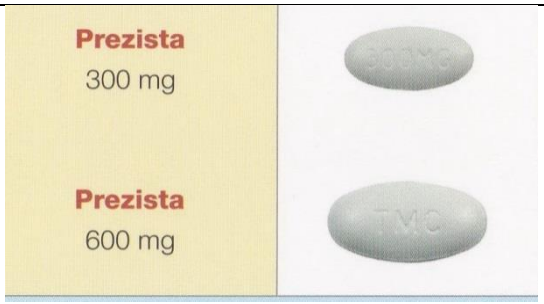
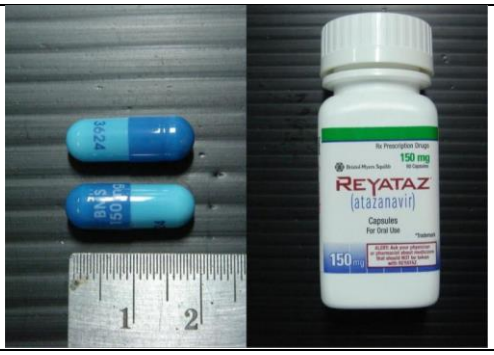
ANNEX 4 Antiretroviral drugs: tablet, dosage and side effects

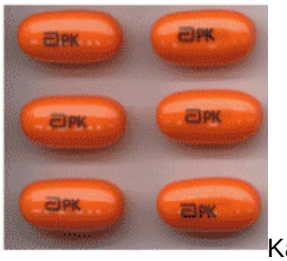
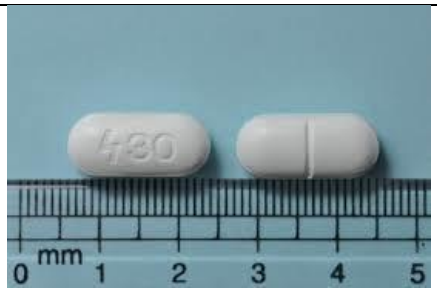
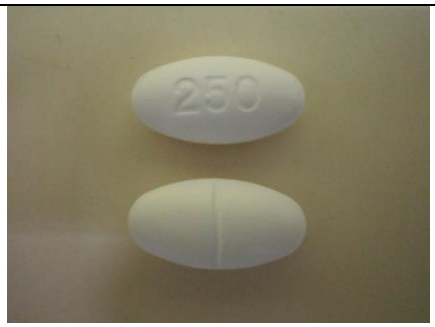
<table>
<tr><th colspan="5">NRTI</th></tr>
<tr><th></th><th colspan="2">Generic Name</th><th>Tablets</th><th>Side effect</th></tr>
<tr><td rowspan="3">1</td><td>Zidovudine
AZT</td><td>ANTIVIR</td><td rowspan="3"> 
  </td><td rowspan="3">Nausea vomitting
Anemia
Nail discoloration</td></tr>
<tr><td colspan="2">Antivir 100 mg
2-3 tablets every 12 hrs.</td></tr>
<tr><td colspan="2">Antivir 300 mg
I tablet every 12 hours</td></tr>
<tr><td rowspan="2">2</td><td>Stavudine
d4T</td><td>STAVIR</td><td rowspan="2"> 
  </td><td rowspan="2">Peripheral neropathy
Lipodystrophy
Nausea vomitting</td></tr>
<tr><td colspan="2">Stavir 15 mg
Stavir 20 mg
Stavir 30 mg
Stavir 40 mg
-30 mg every 12 hours(if body weight < 60 kg)
- 40 mg every 12 hours(if body weight < 60 kg)</td></tr>
</table>

NRTI(cont.)				
	Generic Name	**Trade Name**	**Tablets**	**Side effect**
2	Stavudine d4T	STAVIR	 	Peripheral neropathy Lipodystrophy Nausea vomitting
	Stavir 15 mg Stavir 20 mg Stavir 30 mg Stavir 40 mg -30 mg every 12 hours(if body weight < 60 kg) - 40 mg every 12 hours(if body weight < 60 kg)			
3	Lamivudine 3TC	Lamivir		Nausea, vomiting, hair loss, headache, insomnia(difficult sleeping), fever, rash, tiredness, joint pain Rare: lactic acidosis, liver damage
	Epivir, Lamivir (150), Lamivudine (150) Lamivir (300) 1 tablet every 12 hours			
4	Didanosine ddI	VIDEX		Peripheral neuropathy Diarrhea nausea vomiting Pancreatitis

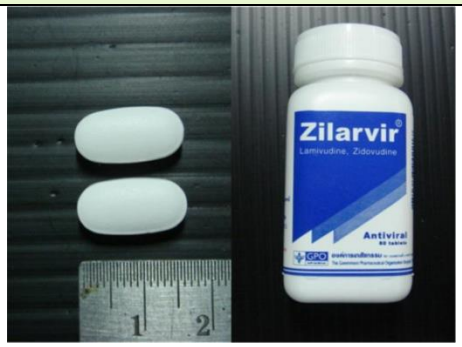
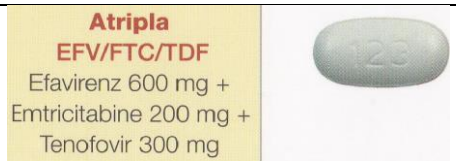
NRTI (cont.)				
	Generic Name	**Trade Name**	**Tablets**	**Side effect**
4	Divir 125 mg 2 tablets chewing before swallowing every 24 hours		 ddI125 mg	
	Divir 200 mg 2 tab chewing before swallowing every 24 hours		 ddI 200mg	
	*taken on empty stomach 1 hour before meals or 2 hours after meals.			
5	Abacavir ABC	Ziagenavir		Nausea vommiting diarrhoea hypersensitivity
	Ziagenavir 300 mg 1 tablet every 12 hours, or 2 tablets every 24 hours			
6	Tenofovir TDF	Viread		Hyper lipidmia
	Tenofovir 300 mg 1 tablet every 24 hours			

NNRTI				
	Generic Name	**Trade Name**	**Tablets**	**Side effect**
1	Efavirenz/ EFV	STOCRIN		dizziness, sleep disturbance, abnormal dreams, impaired concentration, nausea, vomiting, headache, tiredness, diarrhea, anxiety, depression **Recommendation :** avoid taking EFV with fatty food and EFV should be taken before bedtime to avoid being affected by the mentioned side effect
	Stocrin 600 mg 1 tablet once a day (every 24 hours) should take before meal to reduce side effect		original	
	Efavirenz 600 mg 1 tablet once a day (every 24 hours) should take before meal to reduce side effect		 GPO	
2	Nevirapine/ NVP	NERAVIR		liver toxicity(can be hepatic failure), allergic reaction rash, nausea, headache, fatigue, stomach pain, diarrhea Rare: severe rash(Steven-Johnson Syndrome)
	1 tablet(200 mg) once a day (every 24 hours) in the first 2 weeks when starting the medication to reduce the side-effect Then, the drug can be taken twice daily 1 tablet (200mg) twice a day			

Protiase Inhibitor				
	Generic Name	**Trade Name**	**Tablets**	**Side effect**
1	Ritonavir / RTV	Norvir		diarrhea lipodystrophy
	Norvir 100 mg 1 tablet once or twice a day depending on the dosage of other PI			
2	Saquinavir / SQV	Invirase		diarrhea /headache/dry skin/hair loss/ hyperlipidemia
	Invase 500 mg 2 tablets with RTV 1 tablet twice a day, every 12 hours, or 3 tablets with RTV RTV 1 tablet once a day, every 24 hours			
3	Darunavir(DRV)	PREZISTA		Nausea vomiting diarrhea
	Prezista 300 mg 2 tablets with RTV 1 tablet twice a day, every 12 hour			
	Prezista 600 mg 1 tablet with RTV 1 tablet twice a day, every 12 hours			
4	Atazanavir(ATV/r300/100mg	REYATAZ		nausea vomiting headache jaundice

<table>
<tr><th colspan="5">Combine drug</th></tr>
<tr><th></th><th>Generic Name</th><th>Trade Name</th><th>Tablets</th><th>Side effect</th></tr>
<tr><td rowspan="2">1</td><td>Lopinavir/Ritronavir (LPV/r)=133.3/33.3</td><td>Kaletra</td><td rowspan="4">Kaletra SGCs
 
Kaletra (Soft Capsule Gel)
 
Kaletra tab.
 
Aluvia</td><td rowspan="2"></td></tr>
<tr><td colspan="2">3 tablets twice a day, every 12 hours, recommend to take with meal</td></tr>
<tr><td rowspan="2">2</td><td>Lopinavir/Ritronavir (LPV/r)=100/25</td><td>Aluvia</td><td rowspan="2"></td></tr>
<tr><td colspan="2">4 tablets twice a day , every 12 hours, with meal</td></tr>
<tr><td rowspan="2">3</td><td>3TC+NVP+d4T</td><td>GPO-VIR S30</td><td rowspan="2">  </td><td rowspan="2"></td></tr>
<tr><td colspan="2">1 tablet twice a day, every 12 hours (In the first 2 weeks start with GPO-VIR 301 tablet in the morning and take d4T 30 mg and 3TC 150 mg in the evening)</td></tr>
<tr><td rowspan="2">4</td><td>3TC+NVP+AZT</td><td>GPO-VIR Z250</td><td rowspan="2">  </td><td rowspan="2"></td></tr>
<tr><td colspan="2">1 tablet twice a day, every 12 hours

(In the first 2 weeks start with GPO-VIR 250 1 tablet, in the morning, and take d4T 200-300 mg and 3TC 150 mg in the evening.)</td></tr>
</table>

Combine Drug				
	Generic Name	**Trade Name**	**Tablets**	**Side effect**
5	AZT+3TC Zidovudine 300 mg + Lamivudine 150 mg	Zilarvir	 Zalarvir	
	1 tablet twice a day, every 12 hours			
6	AZT+3TC Zidovudine 300 mg+ Lamivudine 150 mg	Combid	 Combid	
	1 tablet twice a day, every 12 hours			
7	TDF+FTC/Ricovir FTC = emtricitabine Tenofovir 300 mg + emtricitabine 200 mg	Truvada		
	1 tablet once a day, every 24 hours			
8	TDF+FTC+EFV	Atripla		
	1 tablet once a day, every 24 hours			

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